UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
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UNITED STATES OF AMERICA,
Plaintiff,

04-CR-1016
(NGG)

versus

United States Courthouse
Brooklyn, N.Y. 11201

RONELL WILSON,

Defendant.
----------x

November 26, 2012
1:00 P.M.

TRANSCRIPT OF CRIMINAL CAUSE FOR HEARING
Before HON. NICHOLAS G. GARAUFIS,
UNITED STATES DISTRICT JUDGE

A P P E A R A N C E S:

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(In open court.)

(Defendant present in open court.)

COURTROOM DEPUTY: All rise. The United States

District Court for the Eastern District of New York is now is session. The Honorable NICHOLAS G. GARAUFIS is now presiding.

(Honorable NICHOLAS G. GARAUFIS takes the bench.)

COURTROOM DEPUTY: Calling CRIMINAL CAUSE FOR HEARING in Docket No. 04-CR-1016, United States of America against Ronell Wilson.

Counsel, please note your appearances for the record.

MR. McGOVERN: For the United States of America, Assistant United States Attorney Celia Cohen and James McGovern.

Good afternoon, Your Honor.

MR. BURT: Michael Burt, Colleen Quinn Brady and David Stern for the defendant.

THE COURT: Good afternoon. Please be seated in the back.

Is there anything before we get started with the first witness, who is Dr. Shapiro?

MR. BURT: Correct.

THE COURT: Anything? I have a letter. I have a letter here from the government and a response from the defense regarding a discovery question.

MR. McGOVERN: Yeah. We've been having conversations with the defense about their willingness to produce, you know, 26.2 or what typically would be referred to

as 3500 material. And we were expecting to get a production from them, and then yesterday we were advised by Mr. Burt and fairly stated in a final way that he had no intention of producing his E-mail communications with all of his expert witnesses, relying on work product and attorney-client privilege. So I just did some quick research, and it appears that the Supreme Court of the United States said that those two privileges are not available when you actually call the witness to the stand, and Rule 26.2 says that he has to turn over any prior statements he has in his possession that are made by his witnesses who will be witnesses for the defendant in his behalf.

And I apologize for raising it with the Court last night, but it was kind of like the only time I could raise it. And Mr. Burt told me that if I wanted to get this stuff, he was going to -- that it would require the government making a formal application to the Court. So that's what I did.

THE COURT: Mr. Burt?

MR. BURT: Your Honor, this issue just recently arose in the last day or so.

THE COURT: God knows you people haven't had enough time to raise issues.

MR. BURT: Right. Right. We were served with a subpoena on October 25th, calling for a very narrow range of E-mails. The Court resolved that issue. We are prepared to

address that issue with the witnesses. And then in the last couple of days, counsel started engaging me in conversation about, well, what about all your E-mails? What about things that you said to the experts in E-mails and they said back?

THE COURT: How would something that counsel said to the experts qualify as the experts' statements?

MR. McGOVERN: That's absolutely true. We're not asking for Mr. Burt's strategic statements that he's making. What we're entitled to are the statements that are being made by his experts. If he believes there is information in there that he doesn't want us to see from his side, the appropriate remedy for him is to submit the E-mails to the Court and let the Court excise those portions that are of that nature.

But I think something's very important here, Your Honor. Mr. Burt's talking about this as if this is an 11th hour matter by the government. In fact, what we subpoenaed from Mr. Burt was very specific information --

THE COURT: Would you speak up into the microphone.

MR. McGOVERN: What we're seeking here --

THE COURT: You have to turn toward the microphone.

MR. McGOVERN: The information that we sought from Mr. Burt previously was information that would not necessarily have been in his custody. That would've been E-mails between the experts. We did not intend by those subpoenas to discharge Mr. Burt or the defendant of his 26.2

responsibilities. Those statements, if he has statements from his experts about the matters about which they're going to testify in this courtroom, the government is entitled to those statements. It's a plain reading of 26.2. And there's -- there should be no reason to say that the government somehow held back. Because in every case in this courthouse, everybody expects that 3500 statements of the are going to be provided in advance of the hearing. We expected that they would provide that information to us, they didn't, and now they're trying to assert a privilege that the Supreme Court says doesn't exist.

THE COURT: Mr. Burt?

MR. BURT: Well, a couple of points, Your Honor. First of all, 26.2, as he said, plain reading of it, if the Court looks at it, doesn't apply to an Atkins hearing. It talks about a trial, a expression hearing, very specific proceedings in there at which 26.2 applies, and there's no indication that it applies in this type of hearing. That's number one. Number two --

THE COURT: An Atkins hearing is a very unusual kind of hearing, and I dare say that the framers of this rule may not have even considered Atkins hearings when they were considering any amendments to this rule. I mean, I really don't know. I don't know when it was last amended. I don't know -- what about the terminology "a preliminary hearing"?

Couldn't that cover it?

MR. BURT: I think the rule specifies the preliminary hearing being specified is the normal preliminary hearing, not a --

THE COURT: Yeah.

MR. BURT: I just don't --

THE COURT: A 5.1(h) hearing?

MR. BURT: Right. It actually specifies the type preliminary hearing it's talking about. So there's that.

Then there's the 16(b)(2) issue, which is (b)(2) allows work product to be withheld, and it specifically says within -- encompassed within (b)(2) are statements made by a lawyer to an expert and vise versa, as I read it.

THE COURT: Where does it say a statement made by an expert to a lawyer? That's the one that I'm interested in.

MR. BURT: Sure.

THE COURT: It's in your letter?

MR. BURT: It is.

THE COURT: Where?

MR. BURT: Someone took my letter.

THE COURT: I've got your letter.

MR. STERN: I have a copy. (Handing.)

16(b)(2) says, "Except for scientific or medical reports, Rule 16(b) does not authorize discovery or inspection of," and then Subparagraph B says "a statement made to the

defendant or the defendant's attorney or agent by," and then skip down to Subparagraph 2, "a defense witness."

So as I read that language, that would encompass a statement made by a defense witness, who's on the stand, to a lawyer, which is me. And that's what he's asking for. He's asking for statements made by these experts to me.

And I should add parenthetically, Your Honor, the first time they asked this about producing this material was last night. I went through late last night, looked at my E-mails for the two witnesses who are immediately going to be called, that is, Dr. Shapiro and Dr. Olley, and the only E-mails I have, without disclosing the content, are scheduling issue E-mails.

THE COURT: Well, I understand your point, and I'm assuming your good faith. But if in some of these documents there is -- there are statements that run contrary to what's in the expert reports, it would seem that any -- that the opposing party, whoever that party is -- you can look at this from your standpoint and the government's standpoint -- should have the opportunity to question the witness respecting those statements, conclusions, opinions that are contrary to or might be considered contrary to what's found in the final report, right?

MR. BURT: Prior to 2010, I think there would be an argument that that's the case. The problem is that the

cases -- there's one from the Second Circuit, one from the Ninth -- say that Rule 16(b)(2), the work product privilege that's in that rule is broader than the civil rule. And in 2010, the civil rule was amended. And I'll hand that up to the court so the court can see the amended language in yellow. It specifically addresses this issue, and it says that everything's protected except very narrow categories of E-mail correspondence between the lawyer and the expert. And I've represented to the Court that I've gone through my E-mails, and we don't have any E-mails within the categories described in that record, in that rule.

So our position is it's protected by 16(b)(2), number one. Number two, I have gone through my E-mails. I do not have anything that would qualify for these next two witnesses. And I have not searched the others, but I certainly will do so. And to the extent that there is the type of exchange that the Court is referencing, there may be the need -- because these will not be statements in the abstract, and they could be I'm writing something to the expert, the expert says something back. The Court would have to review that, I would think.

THE COURT: Right.

MR. BURT: So I will look and see what I've got.

THE COURT: Why don't you let me know.

MR. BURT: I'll represent to the Court that for the

first two witnesses, I do not have anything in those categories.

THE COURT: Anything else, Mr. McGovern?

MR. McGOVERN: There's one minor matter that I'd like to address with the court because I think it involves a potential problem with our ability to provide foundation for some of our testimony.

An inmate was produced by the government to MDC in the last week.

THE COURT: Produced to whom?

MR. McGOVERN: Produced to the MDC from -- writted in from the state facility.

THE COURT: Was writted into the MDC?

MR. McGOVERN: Writted into the MDC on a government writ. And my understandings is that Ms. Brady paid a visit to that witness in the last couple of days and that Ms. Brady told the witness or asked the witness to meet with one of their experts on Tuesday and that Ms. Brady asked the witness to not inform the government if the witness were to meet with the expert and also counseled the witness against meeting with the government's expert because, in her opinion or what she was informing this gentleman of, was that the government's expert will try to get you to give inaccurate answers or something to that effect.

I'm concerned about this because I think that this

is, you know, problematic inasmuch as, you know, we've been very fair about giving access to witnesses and --

THE COURT: Why did you writ this person in?

MR. McGOVERN: Why?

THE COURT: Was there a request by the defense that you writ this person in?

MR. McGOVERN: No. We writted this person in for potentially being a part of this hearing. So it would be perfectly fine for Ms. Brady to pay a visit.

THE COURT: Right.

MR. McGOVERN: Our problem is what it is she said when she was visiting him, which would cause us concern that there's being influence put on the witness not to speak to the government, and that's just -- you know, being on this side of witness prep, as the government often is, we know that that's a pretty clear violation. We just ask them to cease from doing that.

MS. BRADY: Your Honor, if I may address that? I interviewed this person on Friday after learning that he was at the jail. I went to see him and was completely careful. And what Mr. McGovern has represented to the Court that this person said to them, possibly this morning, is a mischaracterization of what I told the witness.

The witness had no idea that -- why he was writted onto MDC. He assumed that it was us, meaning the defense,

that had done so because on several occasions, Mr. Stern has met with this witness. I said, well, we would like for one of our expert witnesses to talk to you on Tuesday, that's correct. And I said and the government is probably going to have you talk to their experts. And you know, the kinds of questions that we would be asking are the things that you previously told us about what some of his limitations are. And I went through those. I in no way inferred that he shouldn't talk to their witness or inferred that their witness was going to go against us or whatever Mr. McGovern characterized. But I can assure the Court they was very careful.

THE COURT: Maybe I ought to appoint a lawyer for this person so that whoever talks to this witness, I get a story that's, you know, from a third party who isn't -- doesn't have a horse in this race.

MR. McGOVERN: That seems perfectly fine.

THE COURT: I just don't want to be involved in competing representations from competing lawyers at this late date. It's just unhealthy.

I'm going to appoint a lawyer. No one is to see this witness without counsel present. No experts to see him without counsel present. This is a very serious matter. We've been preparing for this for a very long time and to have to put my finger in the dyke at this late date is really not

very appreciated by the Court.

All right. First witness. Call your witness.

MR. BURT: Your Honor, we would call Dr. Bruce Shapiro.

And, Your Honor, would it be permissible for Dr. Shapiro to have a beverage on the podium with him?

THE COURT: He wants something other than water? That would be fine for the witness, as long as he doesn't spill it.

MR. BURT: Thank you.

And, Your Honor, how did the Court want us to mark exhibits in terms of 1, A? Does the Court have a system that you --

THE COURT: We're discussing how to mark exhibits today? I have a courtroom deputy. The courtroom deputy is always available to tell you how to mark exhibits. I'm not going to start discussing with you how to mark exhibits.

MR. BURT: That's fine, Your Honor.

THE COURT: They should've been marked, premarked. I have rules. Mr. Stern knows the rules. He's been here for a long time. He's even getting gray.

BRUCE SHAPIRO, having first been duly sworn, was examined and testified as follows:

COURTROOM DEPUTY: Please state and spell your name for the record.

THE WITNESS: Bruce, B-R-U-C-E, Shapiro, S-H-A-P-I-R-O.

THE COURT: You may inquire.

MR. BURT: Thank you, Your Honor.

I've had premarked as Defendant's Exhibit A a binder of material, and I have a copy for the Court's use.

THE COURT: Thank you.

MR. BURT: Your Honor, I've had premarked as Defendant's Exhibit B a second volume of material and a copy for the Court's use as well. (Handing.)

THE COURT: Thank you.

MR. BURT: May I approach the witness to put Exhibit A in front of him, Your Honor?

THE COURT: Surely.

MR. BURT: And Exhibit B.

THE COURT: Mr. Burt, are you going to be using a PowerPoint?

MR. BURT: I am, Your Honor. I think it's on and ready to go, and copies are in the binder.

THE COURT: Very good. Thank you.

You may proceed.

MR. BURT: Thank you.

DIRECT EXAMINATION:

BY MR. BURT:

Q Could you state your name for us, please?

A Bruce Shapiro.
Q Doctor, can you hear me?
A Yes.
Q You have a hearing impairment, correct?
A Yes.
Q If for any reason you can't hear me, please just let me know.
Can you state your name for us?
A Bruce Shapiro.
Q And could you tell us your business or occupation?
A I'm a physician.
Q Where are you a physician?
A I work at the Kennedy Krieger Institute at the Johns Hopkins University School Medicine.
Q Could you speak up just a little?
A I work at the Kennedy Krieger Institute of the Johns Hopkins University School of Medicine.
Q And what is the Kennedy Krieger Institute? What do they do there?
A The Kennedy Krieger Institute is a facility that cares for children with neurodevelopmental and related disorders.
Q And neurodevelopmental disorders includes what?
A Includes such disorders as intellectual disability, cerebral palsy, autism, mixed receptive expressive language disorders, ADHD and specific learning disabilities.

Q And is this a teaching hospital?
A One of the major functions we have is teaching, yes.
Q And who are you teaching?
A Teaching physicians, psychologists, physical therapists, occupational therapists, speech and language pathologists, audiologists, social workers, educators. It's a wide range of disciplines.
Q Could you characterize the patient population?
A At Kennedy Krieger Institute, we see about 155,000 outpatient visits a year, ranging in age from several weeks all the way through adulthood.
Q And what is your specific role there at the institution?
A I have a number of different roles at the institution. One of my roles is to direct a maternal child health training grant, where we train about 200 graduate students per year. One of my roles is directing the to neurodevelopmental disabilities residency, which trains physicians who have -- who are part of a six-year program that combines pediatrics and neurodevelopmental disabilities. And I see patients at the institute. I do clinical work as well.
Q What are the age of the patients that you see?
A I'll see throughout the whole age span. Most of my patients are children, but I do see patients extending into their 30s.
Q And do you see them for purposes of diagnosis?

A I see them for diagnosis; I see them for management as well.

Q What part your work is involved with diagnosing intellectual disability?

A At the current time, probably about 20 percent of the patients that I see have intellectual disability as a primary or a comorbid diagnosis.

Q And how long have you been at the institution?

A I started at Kennedy Krieger in 1975 as a trainee and joined the faculty in 1977.

Q Could you give the Court a brief review of your educational background?

A Sure.

I did my undergraduate and medical school in a combined six-year medical/liberal arts program at Boston University. I graduated Boston University in 1972. Subsequent to that time, I did my pediatric training at Children's Hospital in Washington, D.C. I was chief resident there from 1974 to 1975. And in 1975, I moved to what was then called the Kennedy Krieger. The original name was much longer, and you can't type that fast. And I've been there since.

Q Does some of your work involve research, writing and teaching in the area of intellectual disability?

A Yes.

Q And could you explain to us what your experience is in that regard?
A I've written a number of articles and chapters relating to intellectual disability. I've also done research looking at cognitive motor interactions in children with intellectual disability. And I've done research relative to cerebral palsy, which is not relevant to this particular undertaking.
Q You said you've done writing in the area of intellectual disability, correct?
A Correct.
Q And could you describe more specifically what you have written in that regard --
A Sure.
Q -- and where it's been written?
A I've written chapters for Nelson's Textbook of Pediatrics, which is the primary textbook of pediatrics in the United States. I've written --
Q You referred to Nelson's Textbook of Pediatrics?
A Yes.

MR. BURT: Could I approach the witness, Your Honor?

THE COURT: You may.

BY MR. BURT
Q Is this the textbook you're referencing?
A Yes. I've written for the 17th, 18th. This is the 19th edition. I've just signed on for the 20th edition.

Q Who is that book for?
A This is for pediatric residents and physicians.
Q And are there various chapters in that book devoted to different topics that would be of interest to pediatricians and other people working in the field?
A The whole book is dedicated to pediatrics.
Q Did you write a specific chapter in that book?
A Yes. I wrote the chapter on intellectual disability that's in that book.
Q And how long have you been writing that chapter for that textbook?
A Since the 17th edition.
Q Is that a standard text within your field in pediatrics?
A This is the primary text within pediatrics.
Q Do you have a specialty within pediatrics?
A Yes. I am boarded in neurodevelopmental disabilities.
Q And what does that mean? What does the field of neurodevelopmental disabilities entail in terms of board certification?
A The training for neurodevelopmental disabilities entails two core years of pediatrics, a year of adult neurology, 30 months of training in clinical child neurology and neurodevelopmental disabilities and 30 months of training in clinical sciences, including things like genetics, neuroradiology, neuropathology, research methodology and

techniques.

Q When did you become board certified?

THE COURT: Around.

BY MR. BURT:

Q Approximately.

A It was so long ago that I can't remember. Let me look it up.

I was among the first people in the United States sub-certified in neurodevelopmental disabilities. And my pediatric certification, I believe, was around 1975.

Q '75. Okay.

Now, in terms of your other writings, are you familiar with this book, Children with Disabilities?

A Yes.

Q Who is this addressed to in terms of audience?

A This is a book that focuses specifically on neurodevelopmental and related disabilities and one of the two primary textbooks in this. This has a much wider audience. This has an audience primarily of interdisciplinary practitioners, so it's not specifically to pediatricians or pediatric neurologists, although it is very popular with that group.

Q So this is a book about neurocognitive disorders in children, correct?

A Correct.

Q And did you write a specific chapter in this book?
A I wrote the chapter on early identification and intellectual disability.
Q How long is this -- this is the seventh edition, just came out this year, correct?
A Yeah, correct.
Q How long have you been an author on the topic of intellectual disabilities for this particular publication?
A Since the first or second edition.
THE COURT: Are you planning to introduce this in evidence or are you simply identifying it for the record?
MR. BURT: Yes.
THE COURT: If you're identifying it for the record, which is fine, I'd like a more definitive statement as to exactly what this is, who publishes it, when it was published, what edition it is so that we have a complete record.
MR. BURT: Okay.
BY MR. BURT:
Q Let's start with the Nelson's Textbook of Pediatrics. Can you tell me what edition that is and when it was published?
A This one is the 19th edition, and it was published in 2011.
MR. BURT: Could I approach again, Your Honor?
THE COURT: Sure.

BY MR. BURT:

Q Children with Disabilities, the seventh edition textbook, when was that published?

A This was published in -- has a copyright date of 2013.

Q But it's already out?

A Yes.

Q The next publication I wanted to ask you about was a book entitled "Mental Retardation: Determining Eligibility for Social Security Benefits" by the National Research Council. Are you familiar with this book?

A Yes.

Q And are you the -- was that published in 2002 by the National Research Council?

A Yes.

Q What is the National Research Council?

A This was a group that was charged with developing criteria for looking at the adjudication for Social Security eligibility to intellectual disability.

Q In the acknowledgments in the book it says, "We'd like to thank Bruce Shapiro for his paper on differential diagnosis." Are you the Bruce Shapiro mentioned in this book?

A Yes, sir.

Q What was the paper on differential diagnosis that you presented to the National Research Council that is referenced in this book?

A This is a paper that one of the members of the council asked me to prepare to serve as a discussion point for them so that they could ultimately develop their chapter.

Q And the chapter is Chapter 6, Differential Diagnosis?

A Correct.

Q What does that reference, differential diagnosis?

A Differential diagnosis speaks to the other conditions that can appear to be mental retardation and need to be -- I'm sorry, intellectual disability and need to be considered when making the diagnosis of intellectual disability.

Q Now, in addition to writing about intellectual disability, do you also write in the area of learning disabilities?

A I have, yes.

Q Okay. Are you familiar with this book, Learning Disabilities Spectrum: ADD, ADHD and LD?

A Yes.

Q Edited by you and two others authors, Arnold Capute, C-A-P-U-T-E, and Pasquale A-C-C-A-R-D-O?

A Yes.

Q In 1994, correct?

A Correct.

Q Who is this book addressed to, the audience?

A The audience of that book -- that book was the result of an interdisciplinary conference that we had addressing those

issues about a year before the book was published. It was designed to address an interdisciplinary audience, including physicians, educators, psychologists and speech and language pathologists.

Q Okay. And is another book that you edited a book called "Specific Reading Disability: A Review of the Spectrum," edited by the same authors I mentioned?

A And that was a later book that also -- it was an edited volume that came from a conference that we held and again was designed to bring the state of the art at that particular time relative to specific reading disability and approach it from a different perspectives in an interdisciplinary fashion.

Q You're going to be talking about differential diagnosis and learning disabilities in this case, as well as intellectual disabilities, correct?

A Yes.

Q Okay. Now, do you have professional associations that you belong to that are specific to intellectual disability?

A I used to be a member of the AAIDD. At the time, it was being called the AAMR. I've subsequently let my membership lapse.

Q Just for the record, could you tell us what "AAIDD" means?

A The American Association for Intellectual and Developmental Disability.

Q Now, besides your work with patients and your writing and teaching, what other experience do you have in the area of intellectual disability?

A A number -- well, a number of years ago, I consulted to the federal government relative to medical care in people in an institutional setting. They were in the process of developing a class action suit, and they wanted the medical care that was delivered there to be reviewed.

Another experience I had much earlier, probably in the late '70s, was I was a consultant to Forest Haven. Forest Haven was a residential institution for people with intellectual disability that was used by the District of Columbia as their residential institution. It was under a consent decree. And one of the tasks that I served on, I was a member of a team that moved to help by evaluating the residents and not wanting their needs to help Forest Haven regain their medical assistance funding, which they had lost because they were in such violation of the regulations.

Q Approximately how many patients have you seen for the purpose of ruling in or out the diagnosis of intellectual disability?

A A couple thousand.

Q Okay.

Doctor, do you have in front of you Exhibit A, which is a binder of material?

A Yes.
Q Could you just tell us what is in that binder?
A The first part of the binder contains printouts of slides that I hope to be able to use in presenting information regarding intellectual disability and how do you make the diagnosis.
Q Okay.
A The second is a letter that I have written to you outlining my conclusions after reviewing documents and evaluations of Mr. Wilson.
Q Is that your report?
A Yes.
Q That begins on GOV11000?
A That's correct.
Q Okay.
A The next paper in there is my CV.
Q And is that CV true and accurate as of the date it was written?
A As of the day it's written. It probably needs to be updated since it was written 9-30-11. Some of these newer books, for example, aren't in there.
THE COURT: Could we get an updated version of it?
MR. BURT: Certainly, Your Honor.
THE COURT: No hurry, but it would be useful to have.

MR. BURT: With the Court's permission, we'll just substitute a more current version into the one that the Court has.

THE COURT: Sure, as long as the other side receives a copy of it. As we're doing this, I think that, you know, these documents should be put up on ECF by the defense.

MR. BURT: We can do that.

THE COURT: Everything goes up. Everything at this hearing will be placed on ECF so that it's available for all to see.

MR. BURT: Thank you, Your Honor.

BY MR. BURT

Q What else is in this binder, Doctor?

A The next section contains -- and this starts off with GOV 10770, contains my raw notes and some source material that I have reviewed relative to Mr. Wilson, as well as a number of abstracts about the effects of cumulative risk on development.

Q And the next tab?

A The next one, which was government 10800A, are minutes that -- of a meeting that I had with Mr. Wilson back in October of 2012, which took place subsequent to the communication that I had with you.

Q Okay.

And could you tell us what's in the next tab?

A The next tab is a table that summarizes the psychological

testing, the intellectual testing that was performed on Mr. Wilson at various points in his life. And it contains the names of the tests, the examiners, the year that the test was normed, the scores that he attained, the scores using the Flynn effect and the scores reflecting the standard errors of measurement.

Q And the next tab?

A The next document, which in this binder is not numbered, other than page, is a summary of the educational and IQ testing.

Q And the last tab?

A And the last tab was a document developed by Beth Cahill that I got this week, and this document is a roadmap to several very thick binders that I had to go through. So it helps me find things.

Q Just to be clear, that last document was not something you had prior to writing your report, correct?

A No. I just got that this week when I got into town.

Q Is the purpose of this document just to reference the pages for certain documents that you're going to be talking about?

A That's what I mean when I say it's a roadmap, yes.

Q Okay.

And the documents you're going to talk about, are they approximately 10,000 pages worth of material?

A Approximately. I didn't count them.
Q Are the documents that were made available to you attached to your report, which is this first or second tab? Is there an index of the documents, list of records and GOV Bates stamp numbers which lists the documents you were provided?
THE COURT: The end of the report, Appendix A to the report.
MR. BURT: Correct.
THE COURT: Do you see them, sir?
THE WITNESS: Yes. I have it, yes.
A I did not read all of these documents, but these were available to me.
Q In other words, these documents were made available to you, and you used your professional judgment in deciding what you were going to review and rely upon?
A Correct.
Q Okay.
THE COURT: Has the government received all of this?
MR. BURT: Yes, Your Honor. And we have hard copies of all 10,000 pages that people will be referencing. We have a copy of those for the Court if the Court wants to reference those.
THE COURT: Okay. You can provide that.
MR. BURT: I will get to those at some point. We do

have them. They will be here.

THE COURT: All right. Thank you. Please proceed.

BY MR. BURT:

Q Now, Doctor, I want to ask you about your experience as a witness. Do you consider yourself a forensic expert in the sense that that is your daily activity, testifying in court?

A No.

Q Did I provide you with a copy of a subpoena which asks you to produce certain information about your income related to expert witnessing?

A Yes.

Q And was one of the questions on that subpoena how much income you derived as an expert witness in the year 2001?

A Yes.

Q You can answer that question?

A Zero.

Q Did you do any forensic work either in 2001 or at any point in time in your career prior to that time?

A Yes.

Q And tell us what. What was the extent of your forensic work in that time period from when you first became a physician to 2001, a year before the Atkins case was decided?

A In 1985, I was involved with a case of a child who was alleged to have suffered a brain disorder as a result of a vaccine. And I was asked to evaluate the child and render an

opinion about whether the type of brain disorder that he manifested could be done in the absence of motor findings, and that was done under the auspices of my employer at that time. They had contracted with the attorneys and asked whether I would go to Hawaii to do this evaluation. It was a nice house call. And that was in 1985.

My next forensic exploit was in 2000, and this was a case of a wrongful adoption. This was out in Seattle. And the case involved a child and her brother who were taken from their mother's custody based on an allegation that she had memories of things that happened to her when she was roughly two years old and was able to -- and signed off, saying these are the things that happened to me in such great detail. And the crux of the -- the crux of my involvement on that one -- in that case, I had to testify. The crux of my involvement was whether such a type of memory was indeed possible for a child who was two and under at the time that the incidents were alleged to have occurred.

Q So neither of those case his anything to do with making money off of testifying about intellectual disability?

A No.

Q Would that be fair to say?

A It's fair to say it, yes. No, I did not make any money from it about intellectual disability.

Q And you're familiar with the Supreme Court's decision in

Atkins?

A Yes.

Q Did you have some involvement with the Atkins case itself?

A Yes.

Q What was your involvement?

A I was asked to render an opinion about whether or not Darrell Atkins was intellectually disabled on remand. So this was after the Supreme Court had ruled, the case was kicked back to the state court, and at that point the prosecution was going to put on a resident who did his pediatric -- a physician, rather, who did his pediatric residency at my institution, so I knew him when he was a resident. And he happened to quote my chapter in the 17th edition of Nelson; and as a consequence, I was asked to serve and render an opinion and possibly testify if it came to that point.

Q And did you end up testifying in the Atkins case?

A No.

Q How much money did you make on that case?

A None.

Q Zero?

A Zero.

Q Okay. Did you have any other experience testifying or making money off of Atkins litigation?

A The only Atkins litigation that I have been involved in,

other than the Darrell Atkins case and this one, was the one involving Earl Davis.

Q And how did you become involved in the Earl Davis case? That was in Baltimore, Maryland in approximately 2009?

A Yeah. I was local. I had been involved with the Atkins case. The novelty of the Davis case was that the question of intellectual disability was going to be discussed before the trial took place, and I found that to be interesting. From each of these three cases that I've been involved with, I found them to be instructional to me in a number of different ways, even though they're all deemed Atkins cases, but they teach me different things.

Q How much income did you derive from the Earl Davis case?

A Earl Davis, I earned $16,000.

Q And was that money to you or to the institution? How did that break down?

A There was a split that involved me and the institution.

Q So how much did you make versus what you had to give to your employer?

A I ended up making about $10,000 from the Davis case.

Q Okay.

Would it be fair to say that your income is not substantially derived from testifying as an expert in Atkins litigation?

A Or in any other.

Q Any other area of forensics?

THE COURT: You have to say yes, no or whatever.

A It's fair to say that, yes.

Q Would you characterize yourself more as a practitioner, hands-on practitioner in the area of intellectual disability as opposed to a professional witness?

A Yes, I am a hands-on practitioner; and no, I am not a professional witness.

MR. BURT: Your Honor, at this time, I would offer Dr. Shapiro as an expert in the general area of intellectual disability.

MS. COHEN: Your Honor, just a few voir dire questions.

THE COURT: Absolutely.

VOIR DIRE EXAMINATION

BY MS. COHEN:

Q Good afternoon, Dr. Shapiro. My name is Celia Cohen. I'm one of the prosecutors on this case.

So you testified about, obviously, your very long career and all your credentials, which of course are very impressive. So I just have a if you questions.

You're currently -- you mainly deal with children, you said. You do do some adults into their 30s, but mainly your practice is with children, correct?

A Correct.

Q And these children are coming to you with either -- they might either already have a diagnosis of something or they might come to you for that diagnosis, correct?
A Correct.
Q And in your practice, you deal, you said, about 20 percent with intellectually disabled individuals or that think they might be intellectually disabled?
A Yes.
Q And you said -- so you're a physician, correct?
A Correct.
Q And that means you're not a psychologist, correct?
A Right.
Q You're not a psychiatrist?
A Correct. Psychiatrists are physicians.
Q Right. But in a different sense, correct? You're an M.D.?
A So are psychiatrists.
Q Right. Because they can medicate, right?
A Correct.
Q Right. You are not a psychiatrist?
A That is correct. I am not boarded in psychiatry.
Q And actually in your practice, particularly when you are considering whether an individual has intellectual disability, you have to consult with a psychiatrist, correct?
A No.

Q So you, yourself provide the IQ test?
A Psychiatrists don't provide IQ tests.
Q A psychologist? Whoever provides -- whoever gives the IQ tests, which would be a psychologist?
A It depends on the age and the functional level of the child.
Q But often in your practice, when you're diagnosing a child, you are looking at someone else's -- a test giver's score of an IQ test, correct?
A Probably about a quarter to a half of the time. The other half of the time, it's going in the opposite direction, where I'm saying I think this child is probably intellectually limited, and I'd like to get an evaluation of his or her cognitive abilities.
Q Okay.

So the point is you, yourself, you don't perform the evaluations, right?
A I do on some of the younger infants.
Q Some of the younger. So what ages typically?
A If anyone has a functional age of under three, I'm probably doing my own evaluations.
Q Now, and how much -- what percent, roughly, is that of your practice?
A Maybe about roughly between 20 and 30 percent.
Q So for the remaining percent, roughly 80 or 70 percent,

you rely on other records in making your diagnosis?
A Yes.
Q Is that correct?
Now, just a quick question about the books that you wrote. You also have experience, obviously, in many areas of developmental disabilities, including learning disabilities, reading disabilities, in particular, which, of course, would fall under the same vein, and also ADHD, correct?
A Correct.
Q So some of your patients might come to you, they might be mentally retarded, they might have a learning disability. You cover all of that, correct?
A Correct.
Q And other than your day-to-day work -- actually, strike that.
Your day-to-day work as a clinician, that generally does not require you to go to prisons, correct?
A Correct.
Q And so other than your forensic work, you don't typically see inmates?
A I have seen children who have come to me in shackles because they're under the care of the juvenile justice system in the past. So this is not entirely new to me.
Q Okay.
So some of these individuals have come to you for

potential diagnosis?
A Correct.
Q Themselves?
A Correct.
Q But you typically do not do competency evaluations, right?
A Typically, I do not do competency evaluations.
Q So you don't -- and you don't evaluate individuals for how they're -- what types of crimes they do, whether they could be a psychopath, a sociopath, things of that nature? That's not your specialty, correct?
A That is correct.
Q And your specialty mainly is not only intellectual disability children but other children with a variety developmental disabilities?
A Neurodevelopmental disabilities.
Q Now, you testified about your work on the Davis case, correct?
A Correct.
Q And that was an Atkins hearing?
A Yes.
Q And that was an Atkins hearing that actually Mr. Burt was involved with as well, correct?
A Correct.
Q And actually the other experts testifying here in this

case also testified in that case as well, right?
A Yes.
Q And you testified that you did the Davis case because you liked it because it was instructional, correct?
A Uh-huh. Yes.
Q You also obviously made money, as you testified, correct?
A Correct.
Q And as you're making money here today, correct? Or not here today necessarily, but today as well as all the other work you've done for this case?
A Correct.

MS. COHEN: Nothing further, Your Honor. I have no objection to this expert.

THE COURT: And the motion is to?

MR. BURT: Qualify him as an expert in intellectual disability.

THE COURT: Motion is granted.

MR. BURT: Thank you, Your Honor.

THE COURT: You may proceed.

CONTINUED DIRECT EXAMINATION
BY MR. BURT:
Q Doctor, counsel brought up one point that I wanted to clear up.

Is intellectual disability a psychiatric disorder?

A It is contained within the DSM. So if you -- and since

the DSM is published by the American Psychiatric Association, they claim some ownership on it. But it is also contained within the ICD, the International Classification of Diseases, both in the ninth and in the 11th editions. So it falls outside of the -- it's not entirely within the purview of any single discipline.

THE COURT: Before you go further, the DSM is the?

THE WITNESS: Diagnostic and Statistical Manual.

THE COURT: I know that there will be many acronyms in the course of this hearing. If the parties could provide the Court with a list of acronyms, it would be useful.

MR. BURT: Yes, we can do that. Actually, I think we provided the court reporter with a glossary of terms. We'll certainly give a copy to the Court as well.

THE COURT: Acronyms can be very confusing, especially when they share letters like I and A and D and letters like that. Thank you very much.

BY MR. BURT:

Q Two publications I want to ask you. The DSM-IV-TR --

A Yeah.

Q -- Diagnostic and Statistical Manual of Mental Disorders, fourth edition. Is that the book you were just referring to?

A Correct. That's the text revision, TR.

Q And when was that published?

MR. BURT: Can I approach the witness?

THE COURT: Yes, you may.

MR. BURT: (Handing.)

A Text revision was published in 2000.

Q And if I understand your testimony correctly, mental retardation, as it was then described, is a disorder that is described in that book as a psychiatric disorder, correct?

I think it's around Page 40.

THE COURT: While he's looking, are you going to be using the PowerPoint in the near future?

MR. BURT: I'm almost there. Probably in the next five minutes.

THE COURT: And do you need the lights down for that?

MR. BURT: I'll let the Court judge whether you can see it. I think you'll be able to see it without the lights being dim.

THE COURT: I would prefer to have the full lighting.

MR. BURT: I think it's okay.

THE COURT: When we get to it, we'll try.

A So it's classed within disorders usually first diagnosed in infancy, childhood or adolescence. And it's -- in the original version was an Axis II, which is personality disorders or mental retardation. DSM has a multi-axial classification. So they talk about Axis I being clinical

disorders, Axis II being personality disorders and mental retardation. Axis III, general medical conditions. Axis IV, psychosocial and environmental problems. And Axis V is global assessment of functioning. There's been some debate in terms of whether -- where mental retardation should appropriately sit.

Q Okay.

And does the book, the DSM, as you referenced it, refer to mental retardation as a developmental disorder?

A Yes.

Q A neurocognitive disorder?

A Yes.

Q And are all psychiatrists experts in neurocognitive disorders?

A Could you repeat the question?

Q Yeah.

Are all -- people who call themselves psychiatrists, are they all specialists in neurocognitive disorders, or is that a subspecialty within the broad area?

A Within the range of pediatrics psychiatry, part of their training involves exposure to children with neurodevelopmental disorders. However, I would not class them as experts as a result of that training.

Q Are they more generalists than specialists? In other words, they may come into contact with -- they are not

specialized in the area of neurocognitive disorders?

MS. COHEN: Objection, Your Honor, leading.

THE COURT: I'm going to overrule it. The expert -- for an expert witness, if it helps, get the information out. I prefer to give counsel some latitude.

MR. BURT: I won't abuse the privilege, but I think in certain cases it could move it along a little faster.

THE COURT: All right. It's not a problem. Go ahead.

A Would you repeat the question?

Q The question is: Psychiatrists are generalists, typically they're not specialized in neurocognitive disorders?

A Psychiatrists deal with the behavioral aspects -- when you talk about child psychiatry, many children with behavioral disturbance in childhood have underlying developmental problems. So to that degree, psychiatrists play an important role in treating the behavioral disturbances that these children manifest.

Q If a general psychiatrist comes across a patient who seems to have a neurocognitive disorder and they want specialized advice and assistance in understanding neurocognitive disorders, what field do they turn to?

A Most likely, if you talk about across the United States, they would turn to psychology.

Q And where does your expertise come into that picture?

A The issue is that there are very few boarded neurodevelopmentalists in the country.
Q How many are there?
A Probably about 6- or 700.
Q In the entire U.S.?
A In the entire United States at this time.
Q So it's a fairly small group of people with this particular expertise?
A Yes.
Q And within the field of neurocognitive disorders, you have focused in part on intellectual disability as one of several neurocognitive disorders?
A Yes.
Q Is part of your responsibility to teach other physicians about intellectual disability?
A Yes.
Q In this case, did you prepare some slides that generally are designed to educate us about what intellectual disability is and to answer some basic questions that are background to the opinions you're going to be offering in this case?
A Yes. I'm hopeful that the slides will be useful in terms of understanding what the issues are.
Q And the hard copies of the slides are in the binder, correct?
A Yes.

MR. BURT: If we could, I'll turn to the slides.

BY MR. BURT:

Q Are you seeing the slides on your screen, Doctor? I am not.

A No, it's searching.

MR. BURT: We had them up before. I'm not sure what the problem is.

BY MR. BURT:

Q Doctor, do I have on the screen a PowerPoint that you're going to use as the basis for your testimony?

A Yes.

Q Are the slides numbered in the lower right-hand corner?

A Yes.

Q When we reference a slide, could you reference the page number so that the record will show what you're on?

A Yes.

Q What are the questions that you're addressing in your presentation?

A On slide two, what I hope to speak to is what is intellectual disability, how do you diagnosis an intellectual disability, specifically, focusing on why is it hard to detect intellectual disability in people with higher IQs. I talk a bit about the factors that affect the diagnosis and also provide some information about what people with intellectual disability are capable of doing.

Q Okay.

And so first defining intellectual disability?

A On Page 4, I think it's important to understand that we're using some terminology interchangeably, that is, intellectual disability and mental retardation. So sometimes when I'm referring to older versions of things, I'll use the term "mental retardation." But I think that as was noted under Rosa's law, public law 111-256 changed the name from mental retardation to intellectual disability for education and health legislation. And that is my preferred usage is intellectual disability as opposed to mental retardation. But again, I use the term "mental retardation" again to reflect some of the older literature.

Q And so as the national standard, Rosa's law changed the terminology, but essentially we're talking about the same thing, mental retardation/intellectual disability?

A Correct.

Q Interchangeably?

A Correct.

Q The next slide.

A Okay. The other thing in terms of Orienting people to the slides is that if I see the gray book down in the lower right-hand corner, that's going to be DSM-IV-TR, and that's this book here (indicating). And if you see the green book down in the lower right-hand corner, that will refer to the

classification manual. It's called Intellectual Disability Definition Classification and Systems of Support, which was published by AAIDD, and the publication date on that is 2010.

Q All right.

Turning for a moment to the binder that's in front of you that is marked as Exhibit B. Do you see that, the blue binder?

A Yes.

Q If you look in the first tab, does the first tab contain a copy of the DSM sections that relate to mental retardation?

A It contains not only mental retardation but also learning disorders in that.

Q Learning disorders as well?

A Yes.

Q Which we're going to talk about, correct?

A Yes.

Q All right.

And does the second tab of that binder contain the entire -- a copy of the entire green book that you reference, the intellectual disability book by the American Association of -- on Intellectual and Developmental Disabilities, 2010?

A I presume so.

Q So what do we have on the screen right now?

A So what we have on the screen is the diagnostic criteria coming from the DSM-IV for intellectual disability, as it was

called then, mental retardation. And it's significantly subaverage intellectual functioning, an IQ of approximately 70 or below on an individually administered IQ test.

The B criteria are concurrent deficits or impairments in present adaptive functioning, and that is the person's effectiveness in meeting standards expected for his or her age for his or her cultural group in at least two of the following areas. And they speak about 10 areas; but if you count carefully, you'll see 11 areas there because there's a misplaced comma.

Q The misplaced comma is in the book?

A Right.

Q In other words, it's not on the slide, it's in the book?

A It was copied wrong in the book. One of the editors missed it.

And the areas are communication, self care, home living, social interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure. Health and safety are supposed to be one domain.

Q Where do those 11 areas come from? What is the genesis of that part B part of the test?

A This part is -- one of the concerns about the diagnostic criteria for mental retardation was that there was a possibility that people who just scored poorly on an IQ test would be called intellectually disabled. And the reason for

the second set of criteria in large measure is to ensure that the impairment is not just one of test taking, but rather that the impairment moves into everyday life kinds of activities, which is what's captured by the adaptive behavior criteria.

Q And why was it thought that it's not a good idea to focus just on the score, the first -- the A criteria? In other words, you said there was some concern about just focusing on the score. Why was that thought not to be a good idea?

A Well, let me answer that question indirectly, and then you can push me to answer directly.

Q Sure.

A When immigrants, since we're in Brooklyn, came over to Ellis Island, they would be administered IQ tests and perform poorly on those IQ tests and be deemed intellectually limited and with no deficit in their adaptive behavior.

Q So there was a concern about over-diagnosing people based on a test, a test score?

A That is correct. There was a concern about over-diagnosing people based on the test score.

Q Okay. So this is -- the American Psychiatric Association published this book. This is their definition of intellectual disability?

A Yes. And if you actually go back to a previous version of the classification manual, it was probably theirs. Because what happens is that the psychiatric association usually picks

up the AAIDD definitions in the next edition. So as they're preparing for DSM-V, for example, they are moving forward to pick up the definitions that we will talk about shortly.

Q And the definitions that you talk about are the ones set forth in this green book?

A That is correct. These are the AAIDD definitions.

Q And who is this group, the AAIDD? What is their function or role?

A The AAIDD has a long history. It originally started out as the directors of institutions for people with intellectual disability, and they came together to talk about the issues and problems of people with intellectual disability. And I think they probably had their first meetings somewhere around the turn of the 20th century, when the institutional movement was pretty strong, and they have subsequently maintained their focus on the issues of people with intellectual disability. They have two publications, journals that they put out relative to issues focusing on developmental disabilities and specifically intellectual disability, and they have an annual meeting that brings together practitioners with a wide variety of backgrounds to talk about the issues of intellectual disability.

Q This green book published in 2011, it's the 11th edition. So I take it there are 10 previous editions of this manual?

A That's correct.

Q And is the purpose of the manual to set forth -- among other things, is one of the purposes to set forth standards for defining what intellectual disability is and how to diagnosis it?

A That's the main purpose of the manual is to do that, yes.

Q And how well accepted are the guidelines set forth in this manual within the field of intellectual disability?

A I think it's so well accepted that the American Psychiatric Society will typically change their definitions to match these. And as I said, the DSM-IV and the DSM-IV-TR came from the tenth classification manual. And what they're proposing for DSM-V, Diagnostic and Statistical Manual V, will match these.

Q So in terms of who's actually defining the standards, if I'm understanding you correctly, the AAIDD defines the standards, and then the American Psychiatric Association has been adopting those standards within the book?

A That's been the recent history.

Q Okay.

THE COURT: Can I ask just to break in for a moment?

MR. BURT: Yeah.

THE COURT: The Supreme Court has identified mental retardation as a disability. And intellectual disabilities, is that a -- is that an umbrella under which mental retardation is found or is this a new nomenclature? What are

we -- what is the similarity between what the doctor is expert in and mental retardation? I think that's going to be a question that's going to arise over and over in this hearing, and I would like his expertise on the subject. When you get to it, but we do need to address it.

MR. BURT: Well, I always like to address the Court's questions as they come up because you're the fact finder here.

So could you address the Court's question?

THE WITNESS: If I may read to you?

THE COURT: Of course.

THE WITNESS: "The term 'intellectual disability' is used throughout" --

THE COURT: Please read more slowly, though, because both the court reporter and I read more slowly than you.

BY MR. BURT:

Q First of all, could you reference the page and what publication, because I think the book is reprinted as Exhibit C. So we're just going to need what page you're reading from.

A I am reading from Page 3 in the classification manual, part one. It says: "The term 'intellectual disability' is used throughout this manual to replace the previously used term 'mental retardation.' The term ID is preferred because it, A, better reflects the changed construct of disability

that is described more fully in Chapter 2; b, aligns better with current professional practices that focus on functional behaviors and contextual factors; c, provides a logical basis for understanding supports provision due to its basis in socio-ecological framework; d" -- and this one I think is very important -- "is less offensive to people with disabilities; and E, is more consistent with international terminology."

Q So is that, then, just a change in terminology? In other words, they mean exactly the same thing, but they are changing what used to be called mental retardation to now refer to it as intellectual disability?

A That is correct.

Q And intellectual disability is not a broader term? It doesn't encompass disabilities other than what used to be called mental retardation?

A That is correct.

Q They're equivalent? So when you talk, use those, you're using them interchangeably?

A And DSM-V will be calling it intellectual developmental disorder. So there will be a number of different names that come in. Rosa's law, which was on the previous slide, spoke to the federal government mandating this as being exactly the same when talking about health and education law.

THE COURT: Intellectual disability?

THE WITNESS: And mental retardation. It will be

used equivalently.

THE COURT: All right.

MR. BURT: Hopefully that answers the Court's question.

THE COURT: That helps.

MR. BURT: Okay. Good. Thank you.

THE COURT: But if there's documentation that a different source describes as mental retardation, the term is interchangeable with intellectual disabilities for purposes of our discussion.

THE WITNESS: Correct.

THE COURT: Is that right?

THE WITNESS: Correct.

THE COURT: Go ahead.

BY MR. BURT:

Q So the slide we have up there now sets forth the definition of intellectual disability adopted by the AAIDD?

A Yes, that's correct.

Q And walk us through and tell us how it's different from the previous definition that we had up there.

A It's different in a couple of different ways. Let me go through first.

"Intellectual disability is defined as a disability characterized by significant limitations in both intellectual functioning and adaptive behavior as expressed in conceptual,

social and practical adaptive skills. This disability originates before age 18." And this is on Page 6.

The differences that I think are important to note is -- number one is that they don't specify an IQ cutoff score. I think that this --

Q Unlike the DSM, where their first criteria is specifying a number, correct?

A That's correct.

Q AAIDD doesn't have a number?

A The second thing that is different is that they dealt with adaptive behavior as three constructs instead of 10. And I think this actually simplifies things and makes things a little bit more easy to operationalize. And the three areas that they talk about are conceptual, social and practical adaptive skills. The conceptual are things like functional academics, learning, thinking. Practical adaptive skills for younger children are things like feeding, dressing, toileting; for older folks are things like paying your bills, cooking, following recipes, budgeting. Those kinds things. Social has to do with things that -- following the rules of society, being able to interchange and do things like conflict resolution. To be able to seek help when you need it. To, in a sense, be a good citizen.

Q Okay.

A We'll talk a little bit more about that later.

The other point that is in both of these definitions is that the disability originates before age 18. And that, I think, is an important point that is often misinterpreted.

Q How so?

A The requirement of originating before age 18 is that it doesn't mean that the diagnosis has to be made before age 18. It basically means that the symptomatology needs to be recognized as being present, that there's something that is -- some area of delay exists before age 18.

And this is to distinguish it from young people who have adverse interactions with automotive conveyances at age 25 or a guy who goes diving into water that's too shallow and ends up with a significant head trauma. It's to distinguish it from things like Alzheimer's disease that occur in older people. You can understand how someone with Alzheimer's disease could meet these criteria if it didn't have an age limitation on it.

Q Okay.

So in terms of equivalency between the two definitions, what is the understanding?

A I think that both groups take the three core aspects and endorse the requirement of having all three. And that's the cognitive dysfunction, the adaptive dysfunction and the age criteria.

Q Does the green book have what they call at Page 1

essential assumptions that the whole theory is based on?

A Yes. On Page 8 of the slide, Page 1 of the manual, basically when they talk about making the diagnosis, there are a number of assumptions that need to be made about the whole construct. One is that limitations in present functioning must be considered within the context of the community environs typical of the individual's age, peers and culture. Second, the valid assessment needs to consider cultural linguistic diversity as well as differences in communication, sensory, motor and behavioral factors.

Q What does that mean?

A This is -- the Number 2 assumption gets to some of the things we talked about relative to the Ellis Island example. It also speaks to the fact that if you have somebody who is deaf and you and give them an IQ test, they're not going to perform very well on that test unless you make accommodations for their hearing or in place of people with severe visual impairment, being able to modify or use instruments that are appropriate for somebody with visual impairments.

Q Okay.

The next assumption?

A Yeah. The next assumption, Number 3, which is a very important one because one of the other misconceptions that we run into when dealing with this is failure to recognize that people with intellectual disability may have areas of strength

as well as their areas of weakness. Because everyone tends to focus on the weakness, somebody having an area of strength doesn't necessarily exclude the diagnosis of intellectual disability. And we'll cycle back to that in a little bit in terms of what that means practically when we start talking about it.

Q Okay.

A I think the idea that you have to have all your scores in the range of intellectual disability to be called intellectually disabled is incorrect.

The Number 4 assumption is that one of the important purposes of describing these limitations is to develop a profile of supports which would aid the person. And the fifth one, which is linked to that, is that, with personalized supports, with appropriate kinds of management, the life functioning of a person with intellectual disability will likely improve.

Q So those last two about supports, if you give supports to someone, their life and functioning is likely to improve, is that counter to some stereotypes that beam have IQ or mental retardation being an invariant trait that never changes?

A I think that the important point here is that IQ describes a state of functioning. And intellectual disability is a functionally derived term. And the important point is that people with intellectual disability can't do anything and

never improve are two stereo types that I think increasingly as a society we're moving from. I think that it's important to know that there are children that I see who grow into the diagnosis and children who grow out of the diagnosis, you know. And some of these children are in their twenties when they do it. So it's not quite just children.

THE COURT: Is that because their strengths sometimes develop and the weaknesses or the disabilities tend to be subsumed by the strengths? In other words, they succeed in certain respects that can be measured and they do well.

THE WITNESS: Yes.

THE COURT: And that those disabilities therefore become less significant in their overall lives as they live them?

THE WITNESS: Yes. I think it's -- we will talk about that a little bit more, but "yes" is the answer to your question specifically.

THE COURT: All right. Go ahead.

BY MR. BURT:

Q One of the assumptions is that valid assessment considers cultural and linguistic diversity. That's your Ellis Island example. But is there a caution about that in terms of what should not be overlooked?

A Yeah. You have to indulge me because I like to use examples to answer questions. And I think that they

illustrate the point well.

I had a patient who I was seeing, and the mom was Anglo and the dad was Hispanic, and I talked to the mom. And then I started talking to the dad in Spanish about his son's condition. And she said, why are you talking to him in Spanish? His Spanish is no better than his English. So I think that we can make assumptions based on this.

The other clinical case that we see this in is you'll see a child who is in English language learners. Used to be called ESL, English for a second language. You may see a child in one of those classes for four or five years when a typical young child is in that class for a year, maybe two, and then they're sufficiently able to be reintegrated or integrated into the traditional curriculum. So people are saying well, this is because he's a second language learner, and the answer is no, it's not. It's because he hasn't got the cognitive capabilities, and because he was delayed because people were focusing on the linguistic diversity issues.

Q So when the book says the individual's disability must not be overlooked and the clinician should not allow cultural or linguistic diversity to overshadow or minimize an actual disability, in what kinds of situations, other than what you just mentioned, does that occur where someone is -- the disability is being overlooked?

A It commonly gets overlooked in children who are poor.

Not because they necessarily have more of an intellectual disability, but rather because people are making lots of other hypotheses in terms of the ideology for the child's delays.

Q So for instance, they see poor functioning, and they say he's not functioning poorly because he has an intellectual disability, he's functioning poorly because he comes from a lower socioeconomic background or is not getting the kind of family support he should get; is that what you're referring to?

A He has no books in the house, so therefore he has to be delayed because he has no books in the house.

Q And that is incorrect, to think that way?

A In some cases, it's incorrect, yes.

Q Okay.

And the next slide?

A I think this slide on Page 12 is a little redundant, but it nevertheless makes the point that within an individual, limitations coexist with strengths. And I think that when we look at people with intellectual disability it's very important to look at them as individuals, not just simply as someone who is intellectually disabled or someone who is -- because he has the diagnosis of intellectual disability, that they can't do anything.

Q And what do they reference when they say a limitation is not outweighed by strengths in some adaptive skills? In terms

of outweighing, meaning that you can still make the diagnosis even when the person still has strengths? Or is there some other meaning there?

A You can still make the diagnosis even though the strengths are present, yes.

Q So the strengths don't trump the weaknesses? If you've got weaknesses, the fact that somebody has got strengths does not mean you don't make the diagnosis?

A If you meet the diagnostic criteria for the disorder, then you have the disorder.

Q Regardless of strengths?

A Regardless of strengths.

Q Okay.

And is this language in the book to kind of --

A I'm sorry?

Q Is this language in the book on slide 13 there to kind of remind people that people have strengths and weaknesses that they're --

A I think it's there for two purposes. One is the one that I spoke about, which is not discounting people with intellectual disability because of their intellectual disability and just make the assumption that they can't do anything, which is one of the reasons why we moved to the terminology "intellectual disability." And the other is to say that just because somebody has a relative strength in an

area does not exclude the diagnosis.

Q Okay.

Are there known causes of mental retardation?

A There are.

Q And how do they break down in terms of what causes mental retardation?

A This is from some -- this listing is from a number of epidemiology studies and is in the manual. This is Page 13 here. And it speaks to the issues.

It's important to note that the epidemiology of intellectual disability may show that there is a much higher percentage of people with mild intellectual disability who have no known cause, but the typical causes we run into are hereditary, chromosomal, things like Down syndrome, prenatal toxins, like alcohol, tobacco, problems during the pregnancy, the things like placenta abruptio, A-B-R-U-P-T-I-O, which is the separation of the placenta from the uterine wall, that and eclampsia. Infections may be there, like meningitis. The after-birth trauma. We see this. You may see intellectual disability in a child who's drowned. Poisoning, such as might be the case with lead. Environmental influences are kind of those nonspecific kinds of things that they put in. And then unknown is 30 to 40 percent.

Q You referred to a term "mild mental retardation." Does the DSM classify retardation according to categories of mild,

moderate and severe?

A In older iterations, like when I first started training, it did. And then it took it out. But I think that when people are dealing with intellectual disability -- and I think I used the term "mild intellectual disability" and not "mild mental retardation." But I think that the recognition is that people who are on the milder end of that spectrum are different than those who are in more severe degrees of cognitive dysfunction.

Q Is there score categorization in the old terminology?

A In the old terminology, scores below 70, so 69 to 55, was mild, 54 to 40 was moderate, 39 to 25 was severe, and less than 25 was profound.

Q So what was the difference between, say, moderate and mild in terms of someone's abilities, just in general?

A People who fell into the moderate range of intellectual disability were not going to be independent as adults.

Q At all?

A At all. Their maximal functional age would probably be somewhere around eight or so, plus or minus.

Q And the category mild, is that meant to imply that it's not significant?

A No. Mild is not mild. There are significant impairments in thinking and significant impairments in adaptability?

Q In the old characterization, could mild intellectual

disability people live independently, unlike the people in the moderate category?

A No. Because these are statistical constructs, because we're talking about standard deviations from the mean, there are a lot more people between IQ 65 and 70 than there are between 55 and 65. And those people, many of them, were able to achieve independence.

Q In terms of trying to figure out the causes, is it true that it's easier generally to know the cause when the retardation or intellectual disability gets more severe? In other words, are known causes more associated with the more severe forms?

A Yes. So for example, Down syndrome, which is a major cause moderate or severe intellectual disabilities, is very well recognized and frequently diagnosed as a cause of intellectual disability.

Q In addition to causes, does the green book talk about risk factors for mental retardation?

A Yeah. Maybe we should go on to the next slide if that's okay.

When we're talking about risk factors, risk factors speak to somebody having a greater or lesser degree of likelihood of having a condition. Risk factors don't make a diagnosis. However, there is some interesting literature that suggests that when you begin having multiple risk factors,

even though there may not be a causal relationship, the associations get pretty high.

Q And does the manual actually set forth what the research shows in terms of what the risk factors are for intellectual disability?

A This table 6.1, which is on Page 15, comes from the manual and speaks to a number different factors that have been associated with intellectual disability.

Q And when you're diagnosing intellectual disability, is one of the things you do to look a the person's social history and see how many of these risk factors are present?

A Yes. And it's not just social history. It's also family history, because some disorders run in families. So they can be hereditable.

Q So the categories are prenatal, perinatal and postnatal factors, correct, that are risk factors?

A That is one way to look at it. It's a somewhat dated way, but nevertheless is a useful way of categorization, because we find that often prenatal factors lead to perinatal factors or postnatal factors. So that as a consequence, this categorization is useful for thinking about and useful for teaching purposes. But some of the more recent thinking has suggested that prenatal -- where you time it is not necessarily correct.

Q We'll get to this in more detail later. But in this

case, were there certain risk factors that Mr. Wilson had that you relied upon in forming your opinions?

A Yeah. I think that if you go through this table under -- still on Page 15, under biomedical, postnatal Number 3, meningoencephalitis. At about 20 months of age, Mr. Wilson suffered from meningococcal meningitis. Meningoencephalitis refers to an infection of the meninges as well as the brain, and meningitis is more specifically designated to the meninges.

Q So meningitis is a known risk factor for intellectual disability?

A Yes.

Q Is that well supported in the literature?

A Yes.

Q What are some of the other factors that you saw in this case?

A I think that under the social aspects, poverty would be one. Clearly in his case, we have impaired child caregiver interactions, so much so that child protective services -- I'm not sure what you call it in New York -- had to be involved, and ultimately he was removed from his mother's care. Family, poverty again. Under the behavioral side, I think there was at least neglect. Inadequate safety measures. We've had stories of Mr. Wilson being set upon by neighbor kids and bullied early on. Difficult child behaviors I think just

screams throughout his whole career.

Q How about under behavioral, prenatal, parental drug use, parental alcohol use, why are those risk factors for mental retardation and intellectual disability?

A The parental drug use -- I'll do parental alcohol use first. Parental alcohol use, when it's heavy, can be associated with a syndrome called fetal alcohol syndrome, which is a syndrome that is described by physical characteristics as well as extreme hyperactivity and intellectual limitation and very difficult behaviors.

Q Physical characteristics in the sense that you can see the disorder? You can look at someone and get a symptom from appearance?

A Typically, they have small heads. You have to measure them. You're not going to know just by looking at them. You have intrauterine growth retardation. They have small eye slits and a number of other similar kinds of dysmorphias.

Q Can parental alcohol use be a risk factor for a intellectual disability even if the child does not develop fetal alcohol syndrome?

A Yes. The AAP has said --

Q AAP?

A The American Academy of Pediatrics has said there is no safe limit for alcohol use during pregnancy.

Q How about drugs?

A Drugs are a little bit more complicated. When you're looking at intrauterine drug exposure, it is not a neat system in order to be able to do it. When someone's abusing drugs, typically they are doing a number of behaviors that would put a child at risk. So it may not be the drugs themselves, it may be the lifestyle that is encumbered or associated with it. So people who have abused drugs will abuse different kinds of drugs. They may not eat. They may have inadequate nutrition. They may have smoking behavior, and they may drink. All those things make it difficult to say specifically that this drug has caused this condition, but we know that it pulls on a lifestyle that puts a child at substantially higher risk.

Q Are parental drug and alcohol use at play in this case?

A Yes.

Q And why do you say that?

A There are at least a number of reports in the chart by Mr. Wilson's aunt that the mother was abusing drugs during the pregnancy and confirmed in a number of other places. She was at least a crack user, as I remember from reading over the reports. And she was frequently absent. She would be out on binges.

(Continued on the next page.)

Q So these risk factors have to be taken into account in making or ruling out of a diagnosis of intellectual disability?

A I think that they do not make the diagnosis of intellectual disability, but they put the child at greater risk for experiencing intellectual disability.

Q Okay. Next slide.

How can you tell that somebody is intellectually disabled or has an intellectual disability?

A You can't tell by looking at them.

Q Unlike fetal alcohol syndrome?

A Yeah. I mean, there are a number of them. If you look at someone with Down's Syndrome, you are going to know typically that there's something unusual about the way --

Q Characteristic of that syndrome?

A Characteristics.

Q So you move those aside, and if you talk about the overall number of folks with intellectual disability?

A They're probably 15, 20 percent.

Q In the Down's Syndrome category?

A No. In terms of that you would be able to have physical characteristics, and it would be obviously associated with them. But the other 80 percent of folks with intellectual disabilities, as we talked about earlier, more commonly, the

folks who have mild intellectual disability are going to look like everybody else.

Q Can you tell whether someone is intellectually disabled by talking?

A If you talk to them the same way you talk to somebody at a cocktail party, probably not. They will give you the appropriate social kinds of clues and give you the superficial speech. You'll get the who, the what, the where kinds of answers. And when you begin to ask them the how and the why questions, that's when you begin to start seeing.

So unless you're specifically attuned to it, you will miss it. This is something that we will see not infrequently in the hospitals adolescent clinics, that kids come into the adolescent clinic doing poorly in school. And you talk to the kid and you say who is your favorite rock group? Do you have a favorite rock group? They say the Claw, that for all practical purposes of the superficial level, they are saying the same thing that the other teenagers are saying.

And then you start asking them, well, why do you like that group? And that's where you begin to get, but I like that group. I think they're really -- well, why do you think they're good? So those of the some of the things that you talk to and start talking about to them. So it's a superficial conversation. Many of the folks with mild intellectual disability will pass.

Q Can you tell by relying on a lack of a earlier diagnosis? In this society, can you say, well, he was never diagnosed before when he went through the system or he had people look at him, and he wasn't diagnosed, therefore, he cannot be intellectually disabled?

A I think my organization does exceptionally good work in the area of intellectual disability, frankly, with all neurodevelopmental disorders; however, we see not a small number of children who when you see them initially and you test them, do not score in the range of intellectual disability.

Typically, these are children six, seven, eight years of age, and then you see them again, when they're 13, 14, twelve. And they're having major difficulties in middle school or at the end of elementary school for the 12 year olds, and when you test them again, their intellectual cognitive abilities are falling into the range of mild limitation.

Q So they're declining in terms --

A They show a decline, and when we do have new post-ops in psychologist, they come running up and saying, does this kid have a neurodegenerative disease.

So then they pull out the protocols to see what the child was doing on the original testing. And you try to get as many data points as you can, and you then begin to

understand that, no, he's not losing skills. He's just not progressing at the same rate as other folks might progress. And that explains the relative fall off in his IQ.

Q Okay. Next slide.

So what -- those things you just, is that supported by the manuals in terms of --

A No.

Q -- you can't see MR?

A I think that's a direct quote.

Q There are no specific physical features associated with mental retardation? That's from the DSM?

A Yeah, DSM-4-TR.

Q And this is the Earl Davis, correct? From the Baltimore case?

A Yes.

Q Can you tell whether he is mildly mentally retarded by looking at him?

A No, I think Earl looks like he's bored.

Q He's what?

A Bored.

Q But there are no physical --

A There's no physical characteristics that may make you think that he looks at all unusual in any kind of way.

Q Okay. Next slide.

This is from the DSM again?

A Yes.
Q What do they say in here?
A The point on this slide is that there's nothing specific about the behavior of people with intellectual disability. There's no ID, behavior profile. People with intellectual disability have the same kind of behavior disturbances that everybody else has. And most of the people with intellectual disability, frankly, don't have major behavioral disturbances.
THE COURT: Don't have major what?
THE WITNESS: Behavioral disturbances.
BY MR. BURT:
Q But the profiles are mixed? In other words, some can be aggressive and impulsive? Some people aggressive and impulsive, others passive, et cetera?
A Yes.
Q So there is no profile?
A But the classic that they use is actually a pejorative. They're talking about having the whole world go around. They talking about the people with intellectual disability who look like everybody else, behaviorally. They follow the rules as best they understand them. They interact socially, albeit at a more immature level. They, you know, for the most part, they look like most other people.
THE COURT: And many of them, I take it, lead what you would consider ordinary lives without any problems to

speak of, which would raise the question of whether they had an intellectual disability? Is that a fair statement?

THE WITNESS: I think that what happens is that -- commonly what happens with people with intellectual disability is that they develop a relationship with somebody who is not. And that can be a spouse. That can be a kindly neighbor. That can be a friend. That can be a minister -- somebody else in the community who can help them steer through the vagaries of life.

THE COURT: And what is the difference between an intellectual disability and a case of mental illness? What's the difference?

THE WITNESS: If you go back to English common law, people with mental illness had the capacity to be cured. So consequently, the state could not seize their property. They had to be held in --

THE COURT: That's the legal definition.

THE WITNESS: Right.

THE COURT: I'm looking for the clinical difference, not the legal difference, to answer my question. You're no expert on the law, and I'm no expert on the question of mental illness. I'm just trying to understand what the relationship, if any, is between the two concepts.

THE WITNESS: So when we talk about mental illness and we would be talking about things such as depression, such

as anxiety, such as schizophrenia which have to do with mental processes, whereas when we're talking about intellectual disability, we're talking about reasoning and thinking deficiencies.

People with mental retardation -- people with intellectual disability -- I still slip into old speak, so forgive me every once in a while.

THE COURT: That's fine.

THE WITNESS: People with intellectual disability can learn things.

THE COURT: Can what?

THE WITNESS: Can learn things. They learn things at a much slower rate than typical folks.

THE COURT: But people who have mental illness learn things. Many of them are very talented. They're artists and musicians and they can learn things and they do them extraordinarily well sometimes. So how is that a distinction that makes a difference?

THE WITNESS: Because people with mental illness have a normal thinking -- normal thinking and reasoning abilities when their illness is not interfering.

THE COURT: Okay. We might discuss that a little more later.

MR. BURT: Sure.

THE COURT: Why don't we take a ten-minute break?

MR. BURT: Thank you.

THE COURT: And about how long do you think your direct examination of the witness will take today, and will it go into tomorrow?

MR. BURT: We're hoping the whole thing will be finished today. So I'm going to try to speed it up a little. I don't know how late the Court -- I know the schedule was seven.

THE COURT: It says seven, but I can go as long as it takes.

MR. BURT: Yeah. We would like to finish with him today. He's got professional commitments, so --

THE COURT: We also have cross-examination.

MR. BURT: Yeah. That's why I'm going to speed it up a little bit.

THE COURT: Okay. That's fine. Thank you.

Let's taken ten minutes. Thank you, everyone.

(Recess.)

THE COURT: Okay.

THE COURT: All right. Let's proceed.

MR. BURT: We need the defendant.

MS. BRADY: He's coming.

THE COURT: All right. All set? Let's proceed.

I would -- I know we have the basics here, and it's all set forth in the written submissions, and I don't think

that we need to spend a lot of time going over what's in the textbooks, except as it relates directly to this defendant. So if we could just move it along --

MR. BURT: Sure.

THE COURT: -- the Court would really appreciate that, okay? All right. Let's move along.

I remind the witness that he's still under oath.

THE WITNESS: Yes, sir.

THE COURT: All right. Go ahead.

BY MR. BURT:

Q So Doctor, I want to quickly move through these next couple of slides because they back up what you're telling us.

So this, again, is from the manual about physically indistinguishable from people from the general population.

A Yes.

Q Okay. Next slide, please?

Walk and talk like people who do not have disability?

A Yes.

Q Correct?

Next slide?

This slide relates to some guidelines about using what's called verbal behavior. What is verbal behavior? What are the guidelines about this?

A Well, when you talk about folks with more severe

intellectual disability, they will come have deficiencies in the way that they use language. The difficulty is when you're talking about folks at the mild end of the spectrum, their language usage is much, much better and unless you're trained to listen for things like the efficiency of their communication, in addition to what we talked about previously as far as issues relating to the deeper meaning in terms of being able to defend an argument and things like that. You're not going to be able to just by having a casual conversation with somebody who has mild intellectual limitation, necessarily pick that up with mild intellectual disability.

Q How about in this case? Were you able to have a conversation with Mr. Wilson and determine from that anything diagnostically?

A I did have a conversation with Mr. Wilson, and I think this there are a number of things that came through.

One is that he has a sort of sophisticated vocabulary. Many of the vocabulary words that he used, he really didn't understand the meaning of it.

Second is that his conversation is littered with platitudes and basically space holders. So there are things like -- that he would talk about and then throw in something like -- let me not guess. I'm just going to --

Q Do you need to refer to your notes?

A Yeah. (Peruses documents.)

So one example was when I asked him what are the characteristics of a good friend and he said, "Loyalty." And I asked him to define what he meant by "loyalty." He said, death. You will back somebody to the death.

Q And what is that telling you, diagnostically?

A Well, I think that he's having trouble on a number of levels. One is in terms of defining a term like an affect term like loyalty. Because then when I asked him a follow-up question on that which is where he began to have difficulties, "What do you do if you do don't agree with that friend?" Basically challenged his assertion that you would back to the death. He would have trouble with trying to formulate an answer for that follow-up question.

Q So what is the basis for the guidelines in the book, don't use verbal behavior to infer a level of adaptive behavior?

A I think that one goes to the issue of, as we talked about before, the people who talk the talk, but really don't have an understanding of the deeper relationships. So they can spout out associations.

So, you know, I like to pick a rock group. I'm not very familiar with rock groups at this point in my career. I like a rock group. And then you say. Okay. And the other adolescents say the same kind of thing: I like this rock group.

If you asked someone who is not intellectually limited, why do you like that rock group? They'll be able to tell you something about why they like the music. If you ask somebody who is intellectually limited, they may very well have difficulties to explain rationale for their assertion.

And as a result, if you're just dealing with somebody at the superficial level, it isn't going to be apparent, the difficulties that the people are having with reasoning. And I think that one of the key things that we see in people with intellectual disability as a deficit area, it's part of their cognitive ability to reason.

Q Did you see that in this case?

A I think that I did. It was hard to get to in part because he was not very open. But when I began asking him some other things that were more neutral, like when you were with your girlfriend, would you make cookies? And he say yes. And then I said, how do you make cookies? And how would you do it?

And it took me about five or ten minutes before I realized that what he was referring to was taking the Pillsbury package of cookies out of the refrigerator and slicing the cookies off and putting them on the cookie sheet. When I first heard him speaking, I thought he was talking about you starting from scatch and really making cookies. So it took a while for the communication to link in both

directions.

Q I'm going to if I could, go to the next slide and skip it. Go to the next slide and skip it.

Did you create an example that you're familiar with of how someone with intellectual disability can virtually operate what it looks like in the real world?

A Yeah.

Q Tell us what we're going to see?

A This was youtube clip from Jill -- I'm sorry. I forgot her last name. She was a person with intellectual disability with the Northern Virginia Association for Retarded Citizens, known now as ARC.

Q ARC?

A ARC.

Q Meaning?

A The Association for Retarded Citizens. Now it's just called ARC, Incorporated.

Q And this person is someone with an intellectual disability?

A Right. When she was speaking to -- I forget exactly who she was addressing, but she was addressing the pejorative way people with intellectual disabilities were portrayed in a Ben Stiller movie. So one of the characters was alleged to be intellectually limited and she took great umbrage at this and representing her organization spoke to that topic.

Q Is she mildly mentally --

A She's mild.

Q Intellectually --

A Yes.

Q So does this illustrate what someone actually -- the level at which someone can function in that mild range?

A Yeah. I think that she dispels a lot of the stereotypes that we all have in our mind when we think of intellectual disability or mental retardation. I think it's a -- how subtle this can be.

MS. COHEN: Your Honor, I'm going to object to this video, to the relevance of having someone else intellectually disabled talking to see what people talk like. I don't see how that relates to this case in particular.

THE COURT: Well, I might or might not agree with you.

But how long is this?

MR. BURT: I was going to play about five seconds of it, so the Court can get just a feel for her voice. It's much longer, but I'm not going to play it.

THE COURT: The Court is the trier of fact here. There's no jury. And the Court may or may not take this into consideration. Let's just play it -- it could have been played already.

But this was a good opportunity for me to say that

I'm taking a lot of testimony over the next several weeks, but not all of it may be relevant. I will consider what I believe is relevant.

MS. COHEN: Okay. Your Honor. I've seen it. I mean, the person --

THE COURT: Okay. We've had the discussion. Okay? Let's move on. Thank you.

(Video played in open court.)

MR. BURT: That's all I wanted to play, unless the Court wants to see more of it.

THE COURT: Go ahead.

BY MR. BURT:

Q What is that telling us about someone like her who has a mild intellectual disability?

A I think that it just visually emphasizes some of the points that we have talked about, as far as that people with mild intellectual limitation can very much look like everybody else in the world, and can participate in the greater society in lots of different ways.

Q So this slide.

So that's just what people especially at the higher end of the IQ level can do?

A So again, this one -- this slide is put in to deal with some of the stereotypes that people have.

Q Okay. Next slide, please?

And when you say in the slide that people of mild mental retardation can have very up and down profiles, what do you many by that?

A That refers back to the strengths and weaknesses that we talked about earlier, that people are not flat across the board. They're going to have variations in their cognitive profile measured by IQ testing.

Q Next?

A Can we go back one?

Q Yes.

A I think it's also important on this one to emphasize the issue that people with mild intellectual disability really try to integrate into the greater society, try very hard to hide their disability.

Q And why is that?

A Because being called intellectually disabled or mentally retarded is a terrible thing.

So we run a program at Kennedy-Krieger for mothers who are intellectually limited to teach them how to be better mothers and how to take care of their infants. And one of the things that happens is, they will call themselves learning disabled. They'll say, "I'm ADHD." Say, "Well, I never had the opportunity." And then many, many excuses to avoid using the term intellectually limitation or intellectual disability.

Q Is that common within the field? Is that just your own

view?

A No, I think it's very common.

Q Have there been studies about people with mild -- especially mild intellectual disabilities are capable of?

A Yes. This is slide 28. And I think this comes from the National Transition Data Center. This is a data center where people are surveyed, those with mental retardation. There are a number of ways that's done. It's done every number of years, and they ask them what kinds of things that they're doing.

And I think that it's important when we're talking about folks with mild intellectual disability to really focus on the things that they can do, rather than so much on their limitations. And I think some of the things that are important is that they can become loving husbands, wives and parents. And they're interested in sex. And they can open checking accounts. They can have credit cards. They can drive. They can be arrested. And they can show no malevolent behavior.

Q And next slide is a more recent study? This is a -- U. S. Department of Education puts these studies together?

A This is the 2010.

Q And next slide.

What did they find in terms of characteristics of a group of mildly intellectually disabled?

A They found that the vast majority of them are voters.
Q Were voters?
A Were voters. About half of them have been employed outside of the home after high school. You can see between 2005 and 2010, much larger number have gone to develop savings accounts. A larger number have had driver's license. I think this reflects the way that society has been dealing with people with intellectual disability. Things are getting better in certain respects.
Q And next slide?
A About half of them have been stopped by police officers for other than traffic violations. A quarter have been arrested. Commonly, what happens when they're arrested there, there's usually some sort of misunderstanding. And it has to do often with a limited ability to communicate what was going on.
Q Next slide, please?
Is there something called the "Users Guide" that AAIDD puts out?
A The Users Guide is a companion document with the Classification Manual. And what that seeks to do is to operationalize the concepts that are put forth in the Classification Manual.
Q When did that come out?
A This one is published in 2012.

Q Is there a copy of that in Exhibit B there, the binder of literature?

A (Peruses document.) Wrong binder.

THE COURT: In the third tab.

Q Okay. And this is a quote from that Users Guide, correct?

A Yes.

Q Setting forth what the stereotypes are in terms of what people can do?

A Correct.

Q Okay. Next slide?

They also talk about the issue of lack of an earlier diagnosis and how that issue is treated.

A Yeah. There are some -- if you go back. Quite a bit of time, people could be excluded from full school experiences. People could be excluded from school because of behavior issues or cognitive issues and therefore, the diagnosis of intellectual disability may not have been made.

Q In this case, you had a lack of earlier diagnosis, is that correct or is that not correct.

A That is correct. First time that it really begins to surface is when he is around age 11.

But it's interesting, under educational law, you can go through age eight and not be diagnosed as intellectually disabled. They have something called developmental delay and

you could be carried that way for the first eight years.

Q Is that because you can't be diagnosed under a --

A No, sir. That's because they wanted to operationalize it in that fashion, partly because, again, there's a real disincentive to use the term "intellectual disability" or "mental retardation." They want to give children the opportunity to mature a bit more before they're willing to use that terminology on the school side.

And they also do not want to necessarily have the expanse of a full psychological evaluation, which would be required if you wanted to use the intellectual disability. I think you can provide the services.

Q I want to ask you about this third factor here. It says, "There could be a number of reasons why somebody is not diagnosed at a earlier stage." And they say, "The person was given no diagnosis or a different diagnosis for political purposes, such as protection from stigma or teasing, avoidance of assertions of discrimination or conclusions with the potential impact on benefits of the particular diagnosis." Why is that language in there?

A Well, the last part -- let's deal with the last part, that one first.

And that has to do with the concern about self-fulfilling prophesies. If you call somebody intellectually disabled and you have lower expectations, you focus on what

someone can't do rather than focusing on what they can do. What ends up happening is that they live up to their expectation. And consequently, people are disinclined to do that. So that I think that covers the last part of that.

The avoidance of assertions of discrimination have to deal with when we look at the whole area of special education, this is not unique to intellectual disability, rather to all special education -- there seems to be overrepresentation of children from minority group in special education in this country. So there's a disincentive to do that, to the extent that California has precluded using IQ tests for educational purposes. This was a long time ago.

Q When did that concern begin to arise?

A I can't tell you exactly.

Q And the concern was that people would be overly diagnosed within certain ratio or cultural groups?

A Correct. Or linguistics.

Q What impact on the diagnostic system did that happen, once that concern started to become recognized?

A It's -- the concern has been there for quite sometime. I mean, I remember in the nineties, the NAACP talked about pressing suit in Howard County, Maryland, because there were too many African American kids in special education.

Q Okay.

THE COURT: Well, that -- special education covers a

very broad range of disabilities. Not all of them are intellectual disabilities. And some of them may involve behavioral problems that are not the result of intellectual disabilities at all. They may be the result of mental disorders of other kinds.

So when you're talking about intellectual disabilities, that's a subset of a much broader range umbrella, if you will, of special circumstances, isn't that right?

THE WITNESS: Correct. But the it lead is to a begin kind of disinclination to make any kind of educational diagnosis.

THE COURT: Yeah.

THE WITNESS: That will then lead to a later nondiagnosis of intellectual disability.

THE COURT: I understand your point. And one of the reasons for that is historical and that is, whenever there was a kid with a problem, let's put that kid in the slow class. Let's put that kid in the New York City -- the CRMD class, whatever that was. So rather than address a specific problem, they would address the manifestations of the problem and move the child to a different learning environment, where less would be expected of the child and control would be greater, because it there be fewer children in the classroom.

THE WITNESS: Correct.

THE COURT: Right?

THE WITNESS: Correct.

THE COURT: But that doesn't just cover intellectual disability. This covers a very broad range of conditions. So what does that tell us about this defendant? Where are we going here? Frankly, I don't know. I'd like to know more about how all of this relates to the defendant. So we need to get there.

BY MR. BURT:

Q Okay. Let's if you can move ahead to the -- keep going.

I want to talk to you about how what your opinions are on the first prong -- what's called the first prong, the intellectual functioning prong in this case.

First of all, do you have an opinion as to whether Mr. Wilson meets the first prong of intellectual functioning prong in this particular case?

A I believe that he does. And I focused my attention, as discussed in the order, to his function around the time that the crime was committed.

Q You're referencing the order of -- the Court's order?

A The Court's order.

Q Citing forth the language of the pertinent issue here is intellectual disability at the time of crime?

A That's correct.

Q So do you have an opinion as to whether Mr. Wilson meets

the intellectual functioning prong of the test at or about the time of the crime?

A I believe that he does.

Q And could you explain why?

A (No response.)

Q And do you have in your binder a summary of the scores?

A (Peruses document.) Yes. I've a fourth --

Q Fourth tab?

A Fourth tab.

Q All right. And could you just walk us through this chart in terms of when he was given IQ tests, what he was given and what the results indicate to you?

A So just walking through this, his first psychological evaluation was done on the earlier version of the Wechsler Intelligence Scale for children, by Bruce Pharr. And that was -- that test was normal in 1972, and now it becomes relevant in just a minute. He had a verbal IQ of 81, performance IQ of 90 and a full scale IQ of 84.

When you look and correct the full scale IQ for the Flynn Effect, the false IQ came out to 78. And when you put the confidence limits, the 90 percent confidence limits around that for -- corrected for standard measurement, his IQ scores fell somewhere between 72 and 84. And using the average measuring, but if you use the age, which is a little bit more accurate, 71 to 85, is where his IQ would fall.

If you look at the next testing that he was done by Dresner, he was nine years and seven months. This was the third edition of the Wechsler Intelligence Scale.

Q So this is a different version --

A This is a different version.

Q -- of the Wechsler Intelligence Test, correct?

A Correct. And this test typically is scored with a mean of a hundred, standard deviation of 15.

So that he had a verbal IQ of 79, a performance IQ of 81 and full scale IQ of 78. Again, with correction for Flynn Effect, his full scale IQ dropped down to 77. And when you use the age, correction for standard errors and measurement, he came out with an IQ somewhere between 70 and 84. So just about somewhere between one and two standard deviations.

THE COURT: I'm sorry. What did you say at the end?

THE WITNESS: Somewhere between one and two standard deviations. 85 is one standard deviation, 70 is two standard deviations.

THE COURT: Okay. Got it.

BY MR. BURT:

Q So between the first administration at age six and the second at age nine, he dropped six or seven points in full scale IQ, correct?

A Yes.

Q And what explains that difference? How does one go from an 84 to an incorrect IQ?

A Well, I think that if you look at the -- first of all, these are not the same instruments.

Q They're different instruments?

A They're different instruments.

And second of all, if you look at the corrections for standard error measurement, you're really talking about a very small difference between the two examples.

Q And if you -- we'll talk about this in a minute.

If you correct the full scale to account for the Flynn Effect, do you see any difference in the scores of a 77 and a 78?

A It's couple of points, but -- it's a couple of points. I think it is what it is.

THE COURT: What's a couple of points?

THE WITNESS: It moves from a full scale IQ of 78, but the Flynn correction on the 972 is a full scale IQ of 77.34.

THE COURT: It's not a couple of points. It's one point?

THE WITNESS: Yes.

THE COURT: That's a difference. I want you to be accurate about this, Doctor. If it goes from 78.39 to 77.34. That's basically one point. A couple of points is two points.

THE WITNESS: Right.

THE COURT: So I want it to be accurate and precise as can be, considering the fact that precision may not flow from the nature of what is measured here. I understand that.

THE WITNESS: Yes, sir.

THE COURT: But don't say a couple. A couple means two. A point is different.

THE WITNESS: Hard to work math in my head here.

THE COURT: That's okay. Going from 78 to 77. That's one point.

THE WITNESS: Okay.

THE COURT: Thank you.

THE WITNESS: Okay.

BY MR. BURT:

Q Now, let me ask you about scores or IQ tests given at early age, like at age six or nine.

A Uh-hum (affirmative response).

Q In this Social Security Mental Retardation manual that you reference, let me read you some of the -- asks if you could explain it to us. It says, "During the infant and toddler years, when cognitive growth and development are most rapid and consequently least stable, total test scores should be obtained at the time they are to be used in diagnosis or disability determination. For children between the ages of three and six, total test scores might reasonably be

considered valid for more than a year." Is that true?
A I think that it is.
Q And why is that? Why is the score obtained at age three to six only valid for one year?
A Because there have been a number of studies of serial assessments, a large British study that I can -- in the fifties and early sixties that looked at kids in a serial fashion, and just did repeated IQ testing on them to see even in a typical population what the variation was. And the variation on repeated testing was substantial. And in point of fact, IQ did not stabilize as a construct until somewhere around nine or nine and-a-half years.
Q And even at that age, how stable is the score and for how long?
A There were still variations, and typically, they would talk about three years in that manual.
Q So well, it says among children and adolescents between the age of six and 16, total test scores should be considered valid for as long as three years?
A Yeah.
Q Does that mean after three years, that score is no longer a valid measure of the person's intellectual functioning?
A Correct. They would -- you would need to -- they may still be a valid measure, but you would need to confirm its validity.

Q Is this an invalid measure because it -- the IQ is necessarily rising during the fast developmental period or is it not one?

A It may be rising. It may be falling. That's one of the reasons why you need to confirm it.

Q Is this the standard that's set forth in this manual within the field in terms of how long you can trust these scores?

A I think that it comports to what has been suggested through IDEA, which talked to the issue of triennial evaluations in the original law, which was subsequently said that you don't necessarily have to routinely do these psychological tests unless the child is showing evidence of a failure to progress.

Q So did you read in the -- one of the government reports that he said, well, the score we should pay the most attention to is the score at age six.

A I did.

Q Do you agree with that, given what I just read to you?

A No, I didn't agree with it even before that.

Q Why?

A Because I don't think that the IQ is stabilized. As I said earlier, there are children whose IQ scores look like this one did at age six and at age 12 or 13, they may fall into the range of intellectual disability with false IQs in

the fifties and sixties.

Q Is there something about what is being tested at age six that makes the scores at that age suspect or variable?

A At age six, the measurements tend to be much more associational. When you're talking about 12, 13, 14 year olds, you're talking more about the ability to abstract and generalize and do to formal reasoning kind of activities.

Q Okay. And then, the Social Security manual says, "For adults able 18 to 50, living in stable conditions and stable health, total test scores should be considered valid as long as five years." Do you agree with that?

A Probably not.

Q And explain why.

A I think I would be much more inclined for somebody who is stable and doing okay, as to do a test when there's a reason to do a test rather than just doing it rotely.

So if everything is going well in my practice, I'm disinclined to just routinely order IQ tests every five years.

Q What would be the basis for saying that after five years, you should -- it's not valid?

A I think if they're focusing on folks in residential situations, without necessarily having good observation of people who are expecting the person has disabilities.

Q So in this case, where you're being asked to assess intellectual disability at the time of the crime that took

place in 2003, what is the best measure of intellectual disability at that time period?

A It's the measure that occurred proximate to the crime. So it would be -- I would be inclined to look at the evaluation by Drob, recognizing the limitations thereof, and supplemented with -- well, and look at some of the other scores to see whether or not they are the most consistent with the other scores.

Q And what were your conclusions in that regard?

A My conclusions were that if you correct for the Flynn Effect and correct for the standard errors of measurement, which the AAIDD says are two things that you need to do, and apply the 95th percentile for the standard error of measurement, then Mr. Wilson meets the criteria for intellectual deficits in intellectually function.

Q And walk us through that, his corrected score of the 2003 test, was a WAIS-3 score, correct?

A The WAIS is the Wechsler Adult Intelligence Scale. That's the third revision of it. And it's correct at full scale IQ in the Flynn correction was 73.36, and if you used two standard errors of measurement, which would encompass 95 percent, and his scores would fall between 68.76 and 77.96. If you did it by age, it would be 68.62 to 78.10.

Q And is there in practice, a cutout score that you look to, where somebody falls one point above that cutoff score,

you say they can be intellectually disabled?

A The manual -- the AAIDD manual says that there should be no cutoff score. That's there in the Users Manual, as well as in the Classification Manual. The DSM-4-TR speaks to an of IQ of approximately 70.

Q Okay. If you could go forward on the slides?

A May I make one other point?

Q Sure.

A Because I think it's an important one.

And this has to do with the use of a 95th percentile, because when we're talking about standard errors of measurement, this not a thing that's unique to intelligence testing. This is a way in terms of -- so for example, this morning, I did my blood sugar twice, and a common. My first blood sugar came out at 123. My second blood sugar came out, done exactly the same time was 128. Is one wrong or both? They're right. It just says the variation in the measurement.

THE COURT: That sounds like the sale in my bathroom.

THE WITNESS: Yeah. Same kind of thing.

THE COURT: I wait until it goes down, then I stop. Go ahead.

A So I think that what we're talking about here is measurement and not intelligence in this part.

And the other part -- point to make, the choice of

the 95th percentile means that there is a five percent chance that this man's test performance is outside of that range, either above it or below it.

And I think other discussions that I have had is whether the 95th percentile, there is nothing magical about it. It's an arbitrary set. It could equally well have said we use the 99th percentile, which would be approximately two and-a-half standard errors of measurement, which would make these scores look -- because you're interested in precision a bit different than we were beforehand or we can say, well, we can use the 90th percentile. And I think that is an issue.

When we're using these things clinically, like for educational placements, it doesn't matter too much, but my personal belief is when what we're here talking about person's life, we probably should be using the 99th percentile and not having a five percent chance of being off.

I got off on some place.

THE COURT: That's all right. That's fine.

BY MR. BURT:

Q But is there any set standard or guideline out there that says you use 95 or 66 or does it just depend on the purpose for which you're calculating the score?

A I think most people would feel comfortable into the 90 or the 95th, but I think you need to recognize with the 90 percentile cutoff, you're going to have a ten percent

chance of having somebody's true score be outside of that range. At the 95th percentile, you're going to have somebody have a five percent chance of being outside that range.

Q So if you just look at the full scale IQ score that he obtained in 2003, and you would adjust it for the Flynn Effect -- which we'll talk about in a moment -- his score is 73.36, correct?

A Correct.

Q Okay. And the confidence interval tells you the range within which that score -- within which his true score may fall?

A Correct.

Q So it could be as low as 68. It could be as high as 77?

A Correct.

Q And that range will vary, depending upon whether you use 95 percent or 90 or 99?

A Correct.

Q And in terms of what the standards are -- first of all, what are we measuring with these IQ tests? What is intelligence in terms of what an IQ is getting at? Is it mental illness or is it something else?

A The IQ tests are a sampling of behaviors. They're not an ending of themselves. They don't ever capture all of intelligence, just a sample, but they are supposed to be is -- they're supposed to look in to see how people reason, how

people are able to problem solve.

Novel -- let me underline novel. One thing that I always run into when I'm doing infants, is when I'm asking them to stack blocks and two months later, the same kid comes in, and I just hand the blocks to him and they're doing the stacking, because the parents have been working with him on it. There are practice effects that we can see. So the idea is that it's supposed to be novel, when people aren't addressing these things.

Q If you look at that score of 73, if you go to the next slide, the DSM says approximately 70 or below. That's the number that they single out?

A Correct.

Q Right. And that AAIDD manual doesn't specify a number, but they say approximately two standard deviations below the manual?

A After you consider the standard error of measurement.

Q And the next slide, the DSM or the AAIDD says we don't intend for there to be any fixed cutoff score, correct?

A Correct.

Q Next slide?

And they said that the DSM doesn't either. Right? Can't be psychometrically justified?

A Yes.

THE COURT: What does that mean? What does it mean,

it can't be psychometrically justified?

A My reading of it is that there can't be from the standpoint of what you're talking about when you're talking about intellectual disability, there is a bell around the cut point and therefore, you can't say this is where your cut point is, because it would be a bell around there.

THE COURT: So precision isn't really possible.

THE WITNESS: Correct.

BY MR. BURT:

Q Does the DSM recognize that in terms of they say in the language 70, but they also have language saying something else, don't they?

A Correct.

Q Which is what?

A Which is that they picked up from the AAIDD and this is an earlier iteration of talking about the standard error of measurement. That is how it got to the five points.

Q So they say up to 75 --

A Correct.

Q -- will qualify?

A Correct.

Q Okay. Next slide?

Does the federal government take a little bit different approach when they're determining benefits for somebody?

A This slide comes from the Social Security regulations. When the federal government was adjudicating SSI benefits, they got into a somewhat debate in terms of, do we just use the full scale? Do we use the verbal? What do we do to confront asynchronous development, where one set of scores is substantially better than the others. And they basically said they're not going to take that on that debate, therefore, we take whichever the lower score is.

Q Whichever the lower of the three?

A Right.

Q In this case, if you look at the chart, there's a variability. Is there a pattern of variability among the verbal IQ scores and the performance IQ scores for Mr. Wilson?

A I think it's fair to say that Mr. Wilson has asynchronous development, with his performance scores being better than his verbal scores, and there's been a consistent pattern.

Q Not just better, but consistently lower verbal?

A Consistently, yes.

Q What are they measuring here, verbal versus performance? What is the verbal part measuring? What is the performance part measuring?

A The verbal is allegedly measuring things that are mediated through language. And the performance are mediating through nonlanguage things. And the reason why I saying

allegedly is because they will have things on the performance side that you can use a verbal mediation to solve.

So for example on a task called Picture Completion, you're supposed to be able to point out where the missing part is on a picture. And you know, and you are supposed to see where the part is missing and use a visual perceptual kind of approach. But you can also say, this is what a nose looks like. This is what an eye looks like. Look over here, we're missing an ear. We use a verbal kind of thing.

It's very interesting when we're doing functional MRI studies on people, when we do things that are supposedly verbal, the nonverbal areas light up as well. When we're doing things that are nonverbal, the verbal areas light up, as well. So the distinction between verbal and performance is not as straight cut as people think.

Q But if the question here were not whether the death penalty can be applied here or not, but whether Mr. Wilson could receive Social Secure benefits, the federal government would look to either the verbal or the performance or the full scale IQ?

A That's correct.

Q That they would say if one of those is lower than --

A They would take the lowest score.

Q If that statistically justified? Is there a basis for that?

A No.
Q It's just a policy decision?
A I think it's a policy decision.
Q Okay. Now, next slide?
Are there things -- the Court had mentioned, you know, precision in the scores. Are there things that affect the scores in the case?
A Yeah. I think that there are a number of things that we talk about. Measurement error, that's up there. This is slide 42, I think. Yeah, slide 42. Measurement error is relating to the standard error, measure, we have talked about that.
Q The idea that if you keep taking a measurement, you're going to get different measures --
A You get different results within a range and this would upset that range.
The second kind of thing that you see -- and unfortunately, it's not all that infrequent -- is examiner errors. And examiner errors can be prepared in two ways.
One way that it can occur is, as the Judge pointed out the lighting, which is a math record. So I've seen tests where they did the subtraction wrong and came up with the wrong age for the child, so they're off by a year.
Q Coming up with a wrong year can affect the score?
A Throws off everything.

Q Why?
A These are age-related kind of results. So this that you come up with results on the some test scores, which then become IQ scores based on age.

The second kind of things, simple ones like addition and subtest scores. You may end up with an error in that respect.

Other kinds of examiner errors is that they break protocol. Either they give too much time or they do too much encouraging or they accept answers and credit answers that should not be credited or should only get partial credit.

The third kind of broad area that we run into is the Flynn Effect, and this has to do with the aging of psychometric instruments, and we find that with time, that the IQs tend to rise in a population base and there needs to be some correction for that, and that's called the Flynn Effect.

Practice effects come about in two very different ways. When you are giving the IQ test more than once, as we talked about earlier, the novelty isn't there, and therefore people can be expected to score higher the second time around.
Q Is the whole purpose of the test to assess your novelty skills?
A Well, ideally, the ideal of dealing with these things as novel entities, which is why you don't want to test too, too frequently here.

And the performance IQ tends to be more subject to practice effect than the verbal IQ, and there's literature on that.

Q So let me see if I've got this straight: As you give the test more times, the performance part of the test goes up as a function of just how many times you're repeat the test?

A Correct.

Q If the performance IQ gets inflated because of practice effects, does that then effect the full scale IQ score?

A Yes, because the performance IQ and the verbal IQ together form the full -- form the full scale IQ.

Q How do you get the full scale IQ from the two measures?

A Well, when you look at -- the way that the test is structured is there are a number of different subtests and subtests comport to certain theories of cognitive function. So there is a verbal reasoning area. There is a perceptional organizational area. There is a working memory area and there is a processing speed area.

And the different subtests are there and basically, what ends up happening, you can derive a verbal IQ and derive a performance IQ by putting the subtests in there with respect to respective columns. You take the sum of all the subtests that you've given, and it creates a full scale IQ.

Q Looking at your chart in the case, is there evidence of practice effects, and if so, where?

A (Peruses document.) It does seem to be some substantial improvement in his IQ scores as done in the '98 by Gilio. It seems to be -- it seems to be a outrider of being high.

Q And what is that telling you about the validity of the scores?

A I think that the scores may be high there, as well.

Q The full scale IQ?

A The full scale IQ.

Q Not because of any difference in Mr. Wilson's abilities, but simply because of so many times.

A He is more familiar with the materials.

Q The test is being repeated?

A Right.

Q So that score in 2003, the 73.36, you're saying that could actually be lower?

A I'm sorry. Which score are you saying?

Q The 2003 score.

A The 2003 score? Potentially. There's some other issues with that, and that we have moved from the WISC to the WAIS. And this is a different test. They're not testing the exact same thing across time. So you to have to have some caution about interpreting the verbal IQ and performance IQ, because you are comparing Delicious apples to McIntosh. They're not apples -- they are not oranges, but they're not exactly the same thing.

Q So in other words, there is some play in the score because of the practice?

A Because practice, you're comparing false different tests.

THE COURT: Let me ask you this. In '98, he was 15 years old and 11 months. In 2000, he was 17 years old and eight months, which is near the 18 -- point where he became 18 years old.

THE WITNESS: Yeah.

THE COURT: And then in 2003, he was 21 years and five months. If you look at the scores, the FS IQ scores the score in '98 was 80. It was 84 in 2000. And then it went down to 76 in 2003.

So it was the same test? He was more familiar with it by the time you got to 2003. How does that square with what you just said about familiarity?

THE WITNESS: The problem that I had with that testing, that the subscale scores were not provided. There's no additional data to be able to do that other than summary scores, so I can't answer your question for you, Judge.

THE COURT: And the scores in 2000, when he was almost 18 years old, were significantly higher than in 2003, when he was 21 years old and almost 21 and-a-half years old.

THE WITNESS: And also significantly higher than the previous scores, as well. There is some jump when you move from the WISC to the WAIS at the very low end, and before I

would testify to that, I think this -- I would like to have been able to see the protocols and the subtest scores to be able to compare them to see what THE differences were. Unfortunately, that data were not available.

THE COURT: I see.

THE WITNESS: On the Pop examination.

THE COURT: Go ahead.

BY MR. BURT:

Q When you say the protocols, what are you referring to?

A The actual -- when you administer an IQ test, there's a booklet that goes along where you record the responses and are able to kind of look at them.

Q So when you're talking up here about examiner error, is part of examiner error interpreter errors, like he should get --

A One point, as opposed to two points.

Q One point as opposed to two points and if an error is made there, it's going to affect the score one way or another, correct?

A Yes.

Q How do you check for those errors?

A The only way that you can really check for them is to review the protocol.

Q To review the actual answers given?

A Correct.

Q To see if they were?
A Answers written down.
Q Adequately scored?
A Right.
Q Now, from which of these IQ tests do you have the protocols so you can cross-check them?
A Drob.
Q That's the 2003 one?
A That is the one that's there.
Q Okay. What else?
A I believe we have one on Gilio, as well.
Q For what?
A I think we had one on Gilio, as well. I'm not a hundred percent.
Q Gilio or Nathan?
A Nathan, yeah. The earlier ones, yeah.
Q Okay. And in terms of the -- you mentioned something else besides the protocols, which are the subtest scores?
A The protocol is the actual answers that the person is being tested supplied. The subtest scores are what are derived from those answers. And the error that you see with those is sometimes there's an addition error.
Q Okay. In reference to the score at 17 years, eight months that is the Pop WAIS-3, correct?
A That's correct.

Q That's the first time he's given the WAIS-3?
A Correct.
Q Prior to that, he had been given the WISC-3?
A Correct.
Q Those are two different separate instruments, correct?
A Correct.
Q There is any literature about scoring differences between the WISC-3 and the WAIS-3?
A At a young age, the WAIS tends to be more generous. And at a young age, the WAIS starts at age 16.
Q More generous in the sense it will give you higher scores?
A Somewhat higher score.
Q So which are the two of the accurate? If you give a WISC and then give a WAIS-3, which are -- which score is more accurate?
A I believe that if you are doing simultaneous administration and there isn't much overlap in terms of the age. So this is -- but if you are doing an assessment, you get the maximum amount of behavior, then it will probably be given the benefit of the doubt, go with the benefit of the doubt to WISC over the WAIS at that age.
Q Now, you reference subtest scores, correct?
A Correct.
Q And if you look in your tab where you have a summary of

the educational testing --

A (Peruses document.) Yes, sir?

Q -- and go to the very second to the last page in that tab?

A Yes. That's page 30.

Q Thirty-two?

A Thirty-two.

Q You see that?

A Yes.

Q Okay. Does that list the subtest scores for the WAIS-3 that was given by Arthur Drob at age 17?

A It contains the subtest scores, yes.

Q And is there a term called "prorated"?

A Yes.

Q What does that mean?

A When you're prorated, what you do is you -- you may not administer all the subtests for one reason or another and there is a formula for approximating the missing data to come up with an IQ.

Q In other words, there are so many tests for verbal, so many for comprehension, and the protocol calls for giving all the tests, correct?

A All the required tests, yes. There are some supplementals that are on there.

Q If for whatever reason all the required tests aren't

given, then you have to estimate what the person would have scored on the tests if they were given?

A Correct.

Q Okay. In this case, can you tell from looking at the subtest scores whether he gave an entire performance battery?

A Well, there are three tests there that I do not have -- performance side, they do not have subtest scores there. Picture arrangement, simple search and object assembly.

Q So for whatever reason, he did not give those tests, correct?

A Correct.

Q And if you look at the 2003 testing, did Mr. Wilson receive a low score and --

A I'm sorry. I didn't hear.

Q If you look at the 2003 test, were the Digit Symbol test was given, did he get a low score on that one?

A He got a low score in the Picture Arrangement.

Q And how about in Digit Symbol?

A Digit Symbol, he got a very low score.

By the way, just in terms of interpretation, an average score is a ten and a standard deviation is three. So the Digit Symbol score was three standard deviations below. Two standard deviations below.

Q If mr. Pop in the age 17 test had given those tests that he didn't give, that he left out for whatever reason, and

Mr. Wilson had scored similarly to what he scored in 2003, what would be the effect of this score that Pop would have taken?

A He probably would have had a lower score.

Q A lower score? Is this reliability of that test at age 17 affected by the fact that he did not administer -- looks like two or three subtests that he should have administered?

A I think that it would raise questions about that then to have speculated in terms of what those scores would have been. So I think they would raise some questions about how accurate a representation it was.

Q And again, you didn't have the protocol for the age 17 score to be able to double check and see if there were other errors made?

A I don't remember seeing that.

Q So in the test that was given in 2012 by Dr. Denny, the government's expert, he used another aspect, did he not, than what had been given to him in 2003?

A Yes.

Q And what is the instrument he used?

A (Peruses document.) Yes, sir. To just make sure, we're all in the IQ scores?

Q Yes.

A In 2012, he got the WAIS-4, which is the fourth edition of the Wechsler Adult Intelligence Scale.

Q Is the WAIS-4 just an updated version of the test that was given in 2003 or is it different?
A No, it's a redone version. There's some substantial differences. There are a number of subtests that have been added to this. There have been a number of subtests that have been deleted from previous editions.
And one of the things that came off of the WAIS-4 that was there on the WAIS-3 had to do with bonus points for doing things in a speedy fashion.
Q That is no longer the case in --
A That is no longer the case.
Q Was that a skill that Mr. Wilson lacked, doing things in a speedy way?
A He tends to be very slow. From talking to some of they people who have evaluated him, he tends to be very slow and very deliberate in his approach.
Q So what would be the effect of eliminating speed tests in the WAIS-4 in terms of what his score is?
A He would get a higher score.
Q Is the WAIS-4 in fact a different test than the WAIS-3 because of that?
A I think that you could make a case that that's true. I think that there is still insufficient time to really find out what the strength is and weaknesses of that particular test is. It took is a number of years, for example, to find out

that the Stanford-Binet fifth edition undercalled intellectual disability in children.

Q When did the WAIS-4 come out?

A 2006.

Q And all the other tests that he was given have verbal and performance IQ's, correct?

A Correct.

Q Does the WAIS-4 have verbal and performance IQs?

A No.

Q Did they change that as well?

THE COURT: I'm sorry. The WAIS-4 doesn't have performance IQ? Doesn't test for performance IQ?

THE WITNESS: It speaks to perceptual organization and verbal comprehension. You cannot derive a verbal and performance IQ from that. It gives you the four indices that end up with.

BY MR. BURT:

Q Did they state in the WAIS-4 manual that you should treat him as if they're the same, even though they're not. SO if you're doing comparison to use verbal comprehension instead of verbal?

A I mean, what they have done, the WAIS-4 is kind of an interesting test. When they're done head to head between the WAIS-4 and the WAIS-3, the difference between those two tests are basically the standard error of measurement. So I'm not

sure, number one, that it's measuring the same thing, but number two, I'm not sure why they put this out as something that's different or a need for it.

THE COURT: Can I -- here, we have in 2000, the verbal IQ measurement that Pop examined was 78, in '03 on the WAIS-3, also, it was 71. But then, in 2012, it was an 80, which is close to a 78, not far. But it's far from 71.

Then you look at the performance IQ, which now you're telling me is not a performance IQ in 2012, it's something else listed on this chart under performance IQ, doesn't -- it's not asterisks. It's not -- there's no footnote to it. And in 2000, the performance IQ is a 92. In '03, it was an 85. And we're back to a 92 in 2012.

And the full scale IQ for the three testing protocols in 2000 was an 84, in '03 was a 76, and in 2012, it was an 80. So it would seem, just looking at numbers, that the 2000 and the 2012 test results were higher and relatively close compared to the 2003 test results. Would that be a fair statement?

THE WITNESS: I think if you were just looking at the numbers there, it's a fair statement.

THE COURT: And that results in -- when we go to the averages, 95 percent, the standard -- second standard deviation for those three situations, the 2000 and the 2012 are significantly higher than the 2003, isn't that right, at

the second standard deviation, 95 CI or sent CI?

How do we -- how do you analyze these similarities and distinctions among the three testing periods? Is it simply that they're different tests, so we don't know or is there something else afoot here?

THE WITNESS: There are differences in the tests, that's part of it. And I don't mean to underplay that. That's an important part when we go between the three and the four. That doesn't deal with the issue between the 17 year and 21 and-a-half.

THE COURT: It was the same test?

THE WITNESS: Right. And again, the question comes in terms of the other type of examiner errors which was, was protocol violated? How much encouragement did one examiner provide as opposed to another and did they go over the line in terms of how much encouragement they're giving? There is no way of knowing that to be able to interpret those two. The subject, Mr. Wilson, may have given better effort or less good effort at one point in time.

The other thing that I think is potentially relevant although more so on the verbal IQ than on the performance is his vocabulary score may be influenced by the fact that he has taken it upon himself to learn words, so he reads the dictionary, and has the dictionary read to him. So he's been very interested in enhancing his vocabulary and he's

been doing that for a quite a period of time. And may in part explain some of the differences that you see in his verbal IQ.

I do not have an explanation for the performance IQ, other than to say that when you look at the numbers between the '00 and the '03, and approximate competence limits around those two numbers on the PIQ, they're probably not going to be different, as far as standard errors of measurement.

THE COURT: Thank you.

Go ahead.

BY MR. BURT:

Q And you know in terms of the chart, the Denny scores are listed under BIQ and PIQ, because that's what the protocol says to do? Don't they say treat them like they're --

A Correct.

Q But you're -- in the literature binder there, that speed -- are familiar with this article that was published in neurology called, "Testing Limits, Cautions and Concerns Regarding the New Wechsler IQ and Memory Scales"?

A Yes.

Q Written in 2000 by a couple of neurologists?

A Yes.

Q And they say, "With the release of the WAIS-4, verbal IQ and performance IQ scores have been illuminated entirely, thus short reporting the full scale IQ is the only way to present summary scores across multiple subtests is to use composite

scores. To facilitate interpretation of the revised scale, psychologists are advised in the manual that, quote, the terms Verbal Comprehension Index, VCI, and Perceptual Reasoning Index, PRI, should be substituted for the terms BIQ and PIQ in clinical decision making and other situations where the BIQ and PIQ were previously used, end quote. This recommendation, however, is premature.

MS. COHEN: Your Honor, I'm going object to reading what other experts say on the matter, since we have an expert --

THE COURT: Sustained.

BY MR. BURT:

Q If forming your opinion, did you take into account this article?

A Yes.

Q Did you rely on it?

A Yes.

Q And I would pose the same question, without the foundation.

(Continued on the next page.)

MR. BURT: I would pose the same question with that foundation.

THE COURT: So you were relying on another expert's expertise to reach your conclusion? Is what you're saying? I don't know if they're experts. They haven't been -- they haven't been determined to be experts, at least with regard to this Court. But did you rely, in part or in whole, on their views in coming to your conclusions?

THE WITNESS: They have informed my conclusions.

THE COURT: All right. That's fine.

BY MR. BURT

Q And is that a standard thing to do, is to look at the published peer-reviewed literature and form opinions within your field?

A Yeah.

THE COURT: Have there been other opinions of the same ilk, since -- when was this published?

THE WITNESS: This is 2010.

MR. BURT: 2010.

THE COURT: So this is the only one? That's it?

THE WITNESS: This is the most recent one.

THE COURT: Okay.

BY MR. BURT

Q Are you saying that's the only article out there critical of who it's for?

A No. I'm saying that's the most recent one.
Q The most recent. But is what they're saying true, that the performance and verbal have been eliminated from the WAIS-IV?
MS. COHEN: Object to the form of the question, "Is what they say true?"
THE COURT: That's true.
MR. BURT: I'll rephrase it.
BY MR. BURT
Q Do you agree that the WAIS-IV has eliminated the verbal and performance IQ scores?
A Yes.
Q Do you agree that the recommendation to treat what they call "verbal comprehension and perceptual reasoning" the same as verbal and performance -- that recommendation is premature, we don't have enough research and data yet to justify that conclusion?
A Correct.
Q Okay.
If that's the case, is the score obtained on the WAIS-IV something that you can compare to the scores on the WAIS-III and make it a one-to-one comparison and say, "Well, he's higher on the WAIS-IV than he is on the WAIS-III," and figure out a discrepancy there?
A What the authors pointed out -- the direct answer to your

question is yes.

Q And when you take into account confidence intervals -- first of all, do the manuals, the DSM and the AAIDD manual, recommend that in considering a score, you must consider confidence intervals?

A The AAIDD does, yes.

Q All right. And when you take those confidence intervals into account, do you get a range of scores where at least the lower range is within the ballpark of a cutoff score?

A For some of the tests, yes.

Q So when you see a pattern in scores like this, what do you use to reconcile them? And, specifically, is there any clinical judgment involved in deciding, when you see conflicting scores, which ones to rely on?

A This is a difficult case because of a couple of things. One of the things that makes it difficult to analyze is that he has asynchronous development. There's a marked difference, or a substantial difference, between his verbal and his performance IQ. The second thing that, I think, makes this difficult is that the circumstances under which the testing was performed has had frequent testing and, therefore, is subject to what we're calling "practice effect," which is probably really the progressive effect, which is a type of practice effect that occurs when there's multiple, multiple testings. I mean, this young man had five plus three.

And then the last issue that makes this difficult is that I'm being asked to compare instruments across time. And the difficulty with that is not only the difficulty around different instruments but also the issue that it is possible that given the fact that he was in a better environment, one which was more controlled, that he actually has shown cognitive growth since the time of his crime.

MR. BURT: Can you go to Slide 65, please.

BY MR. BURT

Q Are you familiar with and have you relied, in forming your opinions, on an article that was written by Alan Kaufman called "Practice Effect"?

A Alan Kaufman is one of the gurus of psychological evaluation. And, yes, I did depend on this.

Q Okay. And is this article, in fact, cited in the manual when they talk about practice effects?

A Yes.

Q Okay.

What he says here is clinicians should understand the average practice effect gains in intelligence scores for children, adolescents, and adults. The expected increase of about five to eight points in global IQ renders any score obtained on a retest as a likely overestimate of the person's true level of functioning, especially if the test is given within about six months of the original test or if the person

has been administered a Wechsler scale, any Wechsler scale, several times in the course of a few years.

Does part of that statement apply in this case?

A Yeah. The part that applies has to do with the number of times this young man in the course of -- from ages nine seven through fifteen eleven. So in the courses of six years and four months, he had five administrations of the Wechsler scale. So he's getting roughly about one Wechsler test about every 14 months.

MR. BURT: Okay. Slide 67.

BY MR. BURT

Q He says this type of practice effect also makes it difficult to interpret IQs on tests that are administered every two or three years during the mandatory reevaluations of special ed students. Even though the average gain is about five to eight points for various tests, the average range of gain scores makes it feasible for some individuals to gain as much as 15 points due to practice alone.

Do you agree with that?

A Yes.

Q And he's talking there about what you term "progressive error"?

A Progressive error, yes.

Q The error that results from just continuing to give it over and over, not one test and then another one?

A Right.
Q Okay.
A Practice test is, again, just once and then doing it again. Progressive is the multiple repeats. It's more than just one repeat.
Q And if the variance is five to eight points' increase, what does that say about your ability to rely on scores after a certain period of time when they're given over and over again?
A You have to be cautious in the interpretation.
Q Okay.

And in this case, what did that mean to you in terms of looking at these scores and determining that, yes, he does meet this first problem?

A I think that what it did for me was to provide increased latitude in terms of my thinking about the lower limit of IQ, which is to say that, you know -- that, you know, a 72 would probably be okay for me in terms of my interpretation of this.

THE COURT: I'm sorry. What does "okay" mean?

THE WITNESS: That I think that would be consistent -- not inconsistent with intellectual disability.

BY MR. BURT

Q And when you're looking, say, like that score of 73 in 2003 and there's a range there, 68 to 77, do you place any weight on how he's doing in the adaptive-behavior realm of

things? In other words, do you look at how he's actually functioning in deciding where in that range his score probably lies?

A I think that the adaptive-behavior prong needs to be considered when you're thinking about the diagnosis of intellectual disability. And it's not entirely independent of the intellectual arm. These kinds of activities correlate, so that if you do an IQ test and you do an adaptive-behavior measure, there's a strong correlation between those two.

So I think that you might use some of the adaptive information to help you understand more about what -- the way this person is functioning to help you understand and interpret his level of cognitive function.

Q And what were your conclusions about whether Mr. Wilson met the second and third prongs; that is, the adaptive-behavior prong and the onset-before-age-18 prong?

A I think that there is absolutely no doubt that he met criteria on the conceptual aspect of adaptive behavior and there's no doubt that he met on the practical level, based on some of the descriptions of him in his younger life, plus the report of Dr. Olley.

Q And are your conclusions, the basis for your opinions set forth in some detail in your report?

A They are.

Q And in the interest of time, I'm not going to go through

in detail what's in your report; but can you just kind of summarize why you believe he's met both the conceptual and the practical domain aspects of that? Is the criteria you have to have one in three?

A Right. The criteria is one of three.

Q So conceptual, practical --

THE COURT: You can't overspeak each other.

THE WITNESS: Sorry.

THE COURT: That's all right. Did you want to say anything else?

THE WITNESS: No.

THE COURT: Okay. Next question.

BY MR. BURT

Q The three domains, at least in the AAIDD system, are conceptual, practical, and social?

A Correct.

Q And the rules are if he meets one of three, he qualifies?

A Correct.

Q In the DSM there are 11 areas; he needs to meet two of them?

A Two of them, right.

Q Okay.

So you said in the AAIDD classification, he meets practical and conceptual?

A Correct.

Q Explain to us -- just summarize for us why you believe so.
A In terms of the conceptual, he would meet the criteria based on his functional academic scores. These are significantly impaired. This young man at the time of the evaluations -- and I think there's less variation in his educational scores than in his cognitive scores -- was functionally illiterate and functionally not numerate, so he had a significant deficit in functional academics.
Q Is that well-documented in the 10,000 pages of records that were made available to you?
A I think so.
Q Is there any doubt about that deficit? Do you have some hesitation about it?
A No.
Q Okay.
How about in the conceptual -- in the practical?
A In practical, this young man could not work. He had significant limitations in terms of caring for his self-care; and that was spoken to by his then girlfriend, where she talked about having to teach him about how to clean himself and how to dress himself. And he could not shop. He did not do much in the way -- in terms of household activities as well. So I think that in terms of the kinds of things that went into the practical aspects, again, I think he would meet

criteria.

Q How about the age of onset criteria?

A I think we have clear evidence that he was having problems earlier, though there were delayed recognition, because they were overshadowed by the severity of his behavior. Even at age 11, people began raising the question of whether or not he was intellectually limited, and that was contained in the third Elmhurst Hospitalization.

MR. BURT: I believe that's all I have.

Your Honor, I'd move in Exhibit A and B at this point, for this hearing only.

MS. COHEN: No objection, your Honor.

THE COURT: All right. Exhibits A and B are received in evidence for purposes of this hearing only.

(Defendant's Exhibits A and B were received in evidence.)

THE COURT: Cross-examination.

MS. COHEN: Your Honor, would we be able to take a break now just so I can set up?

THE COURT: Sure. How much time do you need?

MS. COHEN: If you wanted, five, ten minutes.

THE COURT: Okay. Let's take a ten-minute break.

(Whereupon, a break was taken.)

THE COURT: We're back on the record.

Cross-examination.

MS. COHEN: Thank you, your Honor.

CROSS-EXAMINATION

BY MS. COHEN

Q Dr. Shapiro, if this becomes a problem, I can move up. So just let me know.

A I can hear you fine.

Q Okay. Great.

Now, the report in this case -- or you called it a "letter," but that's basically your report. I think it was marked as Exhibit A, Tab 2 in your binder?

A Yes, ma'am.

Q Okay.

And that's basically -- we'll call that your report, if that's okay.

A That's fine.

Q And that report -- that report was based on the other experts' information in this case, right?

A I used some of the expert -- other experts' information, correct. But I also reviewed records and drew my own conclusions, based on the record review that I did.

Q Right.

Okay. So you relied on the experts. You relied on the records, right, the record from his past? Correct?

A Right.

Q The records that were created by the other experts; in

other words, the adaptive functioning testing that was done?

A Yes.

Q And so -- and when we talk about records, you looked at psychiatric records, correct?

A Correct.

Q And you looked at educational records?

A Correct.

Q And you looked at IQ scores?

A Correct. They were contained in his medical records and in his educational records.

Q Right. And we've already looked at those scores.

Now, it was not until after your report and the other experts' reports were exchanged with the government that you met with Mr. Wilson, right?

A That's correct.

Q And at that time, you interviewed Mr. Wilson, I'm guessing because Mr. Burt asked you to go and interview him?

A Correct.

Q And that's because meeting with a person who you're diagnosing is important, right?

A Usually, yes.

Q And that's important because it's helpful to get a full picture who this person is, right?

A Correct.

Q And I'm putting aside, you can't look at them. You can't

know from just having a cocktail conversation. So I'm talking from a clinical aspect, right?

A Correct.

Q Now, during that interview you gave Mr. Wilson some tests, correct?

A Correct.

Q You didn't score those tests, correct?

A I scored the mini-mental status on him.

Q And you did not -- based on those tests, you didn't change your opinion or submit a supplemental opinion, correct?

A Correct.

Q Now, some of the -- I mean, I guess I'll call them "testing." I don't know what the correct word is, but you gave him some proverbs, correct?

A Correct.

Q And by "proverbs" I mean some proverbs that people might know, like "people that live in, let's say, glass houses shouldn't throw stones." I actually think you gave "you shouldn't judge a book by its cover," perhaps was one of them?

I'm sorry. Are you looking through your notes?

A Can I help you with that?

Q Yes. I should say -- I don't mean disrespect but, yes, your notes were open, but difficult to read.

A I read my handwriting fine.

Don't cry over spilled milk. The squeaky wheel gets

the grease. Blood is thicker than water. You can't tell a book by its cover. And look before you leap.

Q And the reasons that you give these proverbs to Mr. Wilson, or somebody who you suspect would have mental retardation, is because these types of proverbs test abstract thinking, right?

A Yes.

Q Yes. I mean, your ability to conceptualize and reason, are those the types of things it touches on?

A Yes.

Q And those things are important, right, because when you are talking about diagnosing someone, particularly someone with mild mental retardation -- which, as you explained, is difficult, right, because somebody with mild mental retardation is so close to the line?

And the reason these tests are important is because these are something -- abstract thinking and reasoning are things that are more difficult to improve upon, right?

A I'm sorry. Could you repeat the question?

Q The reason that you test abstract thinking and reasoning with mental retardation is because these things are more difficult to improve upon, correct?

A Well, they're core aspects of intellectual disability.

Q Right.

So I know you talk about, let's say, particularly

someone in prison, right? Let's say even the person was more -- a little bit worse than mild mental retardation, more moderate, let's say, or closer. This person might, let's say, have trouble mopping. And in prison --

A I'm sorry. I'm losing you at this point.

Q You can't hear me?

Okay. So you have someone with mental retardation in prison. Let's just say -- this is a hypothetical -- before prison they had trouble mopping the floor.

A Uh-huh.

Q That same person goes to prison and because of the environment, mopping the floor becomes something they are able to maybe not master, but they can do it, right?

A Correct.

Q So those are the types of things that distinguish somebody with mental retardation, being somebody who can perform -- learn to perform a task, like mopping the floor, versus someone who has abstract thinking, correct?

A Correct.

Q Now -- and, actually, on one of the slides --

MS. COHEN: Can we have Slide 9?

BY MS. COHEN

Q We talk on that slide -- while she's pulling it up -- you talk about this ability to improve.

MS. COHEN: Oh, I'm sorry. It needs to be switched.

Actually, you know what. Don't worry about it. I only have one slide.

BY MS. COHEN

Q My point is, you talked about the fact on that slide that there are certain areas that are more difficult to improve upon. So abstract reasoning and thinking would be one those areas, correct?

A Correct.

Q Now, reason and problem solving are also things that are tested in an IQ, right?

A Correct.

Q And I don't know, but I'm guessing -- I'm assuming -- that's because of what you already testified to, because they're important for getting an assessment of somebody's intellect --

A Yes.

Q -- is that right?

A Let me clarify the question to make sure I understand it.

Q I'll rephrase it a little bit.

A Please.

Q The reason why IQ tests, some of the subtests, specifically test that same concept, abstract reasoning and problem solving -- there are subtests that are designed to test that, correct?

A Correct.

Q And the reason is because, like you've already testified, because those things are mainly stagnant throughout life, right? In other words, you might improve upon them a little bit, but not dramatically, if you have mild mental retardation?

A It depends on the age. So in young children, for example, that statement is not a true statement.

Q Right.

A In adults, it's probably more true.

Q Okay.

Well, we'll take a look at those. But, generally, that's the reason why IQ would test the reasoning and the abstract thinking?

A That's one of the aspects of intellect that they're looking at, yes.

Q Okay.

Now, in your report that we've already referred to -- you have it up there -- you did not go into a real discussion of the IQ scores, correct?

A Are you referring to GOV 1106 and 1107?

Q Yes.

Hold on. We're still looking at your report, correct, the one that's the second tab in the binder?

A Yeah, but which pages, please?

Q Oh, I'm sorry. I'm just saying your entire report.

A Okay.
Q I mean, I can point your attention to a couple of areas where you discuss it, if that helps.
A That would be very useful.
Q I believe page 7.
A Okay. That's GOV 1106?
Q Yes.
A Thank you.
Q Actually, I'm sorry. Go back to the prior page, page 6.
I mean, you touch upon IQ, obviously, in explaining what IQ is and why it's important, correct?
A Try to, yes.
Q Yeah.
And you also explain -- you talk about the Flynn effect, right?
A Uh-huh.
Q And the confidence intervals, correct?
A Uh-huh.
THE COURT: That's not an answer. Say yes or no for the record.
A Yes.
THE COURT: Okay. Thank you.
BY MS. COHEN
Q But with respect to the specific scores here, your report doesn't contain a thorough analysis of the scores, right?

A What I was doing in this part of the report was to help people understand the factors that went in. So unless somebody had some a priori knowledge of SEM, they wouldn't understand. And I think that the table speaks to that. I think that the discussion of Flynn effect -- Flynn effect is something that is not common knowledge, so I thought there was a need to have that.

Q Oh, yes. No, I'm not criticizing that. Sorry.

A So the discussions, then, speak to his adaptive behavior. And basically what I concluded, after reviewing his psychological scores, which were contained in Appendix 1, was that he showed asynchronous intellectual development, verbal scores trailing performance. There was a 14-point discrepancy between verbal and performance IQs on his most recent testing, which at that time -- the information I had was 2003. I saw some later testing -- I saw subsequent testing after this report was written. So this is what I had at the time. And referring to the 2003 testing, his later scores were lower than the earlier ones, which is a pattern that is not uncommonly seen in people with severe language and academic underachievement.

On the 2003 testing, Mr. Wilson's full-scale IQ, adjusted for Flynn effect, is 73. Reported as a confidence interval, as it should be, and that score is between 69 and 78 and, consequently, met AAIDD and DSM-IV-TR criteria for

significant subaverage intellectual function.

Q Okay. Thank you, Dr. Shapiro.

Actually, that was the second -- sort of combining my questions. I was just drawing your attention to the first part, not to criticize what you'd written there, but just to point it out that you touch on IQ generally at the beginning and then this paragraph, you talk about the fact that you're really relying on the 2003 IQ score, right? That's what you just read to us?

A Which was the information that I had.

Q Right. And then the other part that you do in your report about the IQ test is the chart that we've been through on direct examination, correct?

A Yes.

Q Okay. Now, when I said you didn't do an in-depth analysis of IQ, I mean you didn't go through each of the IQ scores, correct? I'm sorry. You didn't analyze each of the correct scores in your report, correct?

A Correct.

Q Instead, you took these scores from the reports, right?

A Yes.

Q And you put them in your own report, in your own chart, correct?

A Correct.

Q Okay.

So, now, the remainder of your report is all devoted to adaptive functioning, right?

A Correct.

Q And even though we kind of, I think, maybe -- I don't know if it was time that we had in your direct, but most of your direct was actually devoted to the general concepts and IQ. And then you gave a quick opinion about adaptive functioning, right?

A Correct.

Q But your report really focuses on adaptive functioning, correct?

A Correct.

Q Now, before -- under the definition of what is "mentally retarded" -- and I'm not talking about this whole confidence interval, and all those things. Those are definitely important.

But under what we were looking at, and what the Supreme Court in *Atkins* was -- and the DSM defines "mental retardation" as a score of 70 or below, right?

A If you say so.

Q Well, I mean, just let's get to the -- we're going to get to the Flynn, and we're going to get to the confidence intervals.

A I have to say I have not read the Supreme Court rulings, so I'll have to take your word.

Q Okay. Well, we'll go with the DSM. I know you've read that, so...

Okay. So -- now, if you put a confidence interval on something and you have a 75, that would probably get you around a 70. So, therefore, it would be the equivalent, correct? If you had 4 of a 75, you might find somebody mentally retarded because with the confidence interval, it could go down to 70?

A It may be somewhat higher than that, but the reason I was hesitating is because I was chastised by the judge for my lack of precision. So I want to be careful.

Q Well, I know that --

THE COURT: No, that's not true, sir. You were chastised by the judge because you said a couple of points' difference, where it was actually one point difference; and that was a simple reading that any first grader could do and come to the conclusion that I came to.

THE WITNESS: Okay.

THE COURT: I'm not chastising you, in general. It was only for that specific mistake, and I wanted the record to be clear. So let's not misrepresent what I'm doing. This is about what you're doing. So stick to you, and don't comment on me. Do you understand me?

THE WITNESS: Yes, sir. I'm sorry.

THE COURT: Do you want to come back tomorrow? Do

you want to get another shot at it?

THE WITNESS: No, sir.

THE COURT: Mr. Burt, would you like him to come back tomorrow?

MR. BURT: I would prefer not, your Honor, but it's the Court's pleasure.

THE COURT: I would rather have him finish tonight, but not if he's going to comment on my statements and my views.

MR. BURT: I think he apologized to the Court.

THE COURT: I understand that. It's not appreciated.

Next question.

MS. COHEN: Thank you, your Honor.

BY MS. COHEN

Q Excuse me.

So let's take the confidence intervals out of it for a moment. Generally, it's 70 or below.

Now, that means that -- or strike that.

The IQ level -- in order to determine if somebody is mentally retarded, the IQ level is the absolute threshold, correct?

A What do you mean by "absolute threshold" in that?

Q Because if my IQ, let's say, is a 90 after we've applied all of the Flynn effect and the confidence intervals --

A Uh-huh.
Q -- you're not going to test me for adaptive functioning, correct?
A Well, I might.
Q In what instance would you?
A Well, for example, if I were looking at you as a potential case of autism, I would want to know how you were functioning in everyday life. And, very commonly, there is a marked discrepancy between cognitive abilities and adaptive abilities in children with autism. So there are examples where I would want to know adaptive behavior, measure it, and get a better understanding of adaptive behavior, in addition to intellectual disability.

We see it, also, in children with spina bifida, meningomyelocele, who --

(Reporter requests clarification)

THE WITNESS: Just use spina bifida.

THE COURT: No, no, no. We're not doing it that way, Doctor. If you use a word -- if you say a word, it goes into the record. You spell it if she doesn't know how to spell it. We don't change testimony based upon what would be easier. I'm the judge. I'll decide what goes in the record. Whatever you say goes in the record.

I think you're having trouble with who's the judge here. I'm the judge; you're the witness. What you say goes

in the record.

THE WITNESS: Okay.

THE COURT: This is a death-penalty case.

THE WITNESS: Yes, sir.

M-E-N-I-N-G-O-M-Y-E-L-O-C-E-L-E.

BY MS. COHEN

Q But the conditions that you just mentioned, those are not -- we're not talking about those conditions here, correct?

A No. But the question that you asked me was if I didn't -- wasn't concerned about intellectual disability, there would be no need to measure adaptive behavior, and I am telling you that that is an incorrect statement.

Q Right. Well, I'm glad you clarified, now that I understand why you might give adaptive functioning.

For mental retardation alone, there are three prongs, correct?

A Correct.

Q IQ, right?

A Cognitive ability or intellectual function.

Q Measured by IQ, correct?

A One of the ways of measuring it, yes.

Q Adaptive functioning, correct?

A Yes.

Q And onset before the age of 18?

A Correct.

Q So if you don't have one of those prongs, you're not going to meet mental retardation, correct?
A Correct.
Q And oftentimes, based on an IQ and clinical observations, even if an IQ is close to 70, if it doesn't meet it, the person testing doesn't think it meets the threshold level of an IQ, adaptive functioning would not be done if they were looking for mental retardation, correct?
A The difficulty with your statements -- and I'm going to say not correct. And let me explain it further, because the AAIDD says that there is no cutoff score for cognitive dysfunction in the first prong. And what you are persisting in talking about is a threshold function that you cannot use.
Q So there's no number we can throw out, and no matter what it is, you perform adaptive functioning. Is that your testimony?
A I find that adaptive functioning is very useful in my clinical practice, so I'm much more inclined to use it than perhaps other people might be.
Q Now, the AAIDD, that's an advocacy group, correct?
A Define an "advocacy group" for me, because I'm not sure what you mean by that.
Q Well, not a professional group.
A No, that is a professional group.
Q They're advocating on behalf of people with mental

retardation or intellectual disability, correct?
A Their purpose, in addition to bringing the issues of people with intellectual disability to the fore, are also to educate and to support training and research in the area, yes.
Q Now, in this case, I'm not asking you if this was a correct thing to do or not. I'm just asking you yes or no. There was no adaptive functioning done in Mr. Wilson's life until now, correct?
A Correct.
Q And Mr. Wilson had, prior -- even prior to 2003 -- from the time he was born until his 18th birthday, he had, I believe, six -- one, two, three, four, five, six, seven -- seven IQ tests, correct?
A Yes.
Q I'm going to put this up, actually, in a minute. So I'll put it there now.
THE COURT: Can we have an identification of what's being placed on the ELMO?
MS. COHEN: Sure. This is Dr. Shapiro's chart, which is already in evidence as Defense Exhibit A. And this was the same chart that was just reviewed on direct examination.
THE COURT: All right.
BY MS. COHEN
Q Now, before we get to this, though -- I'll leave it up

there. But you talked a lot about the Flynn effect on -- or not a lot, but a little bit, on direct examination, correct?

A Correct.

Q And the Flynn effect basically means that over time, people's scores could improve; is that correct?

A No. What it says is that over time, people's scores do improve.

Q And meaning that --

A On a population basis.

Q Right.

Now, do you personally, though, in your clinical practice -- you do not use Flynn, right?

A Usually not, because a couple of points, even four or five points, in the work that I'm doing is not critical.

Q The work that you're doing is not critical?

A The work that I'm doing clinically.

Q Oh, clinically.

I mean, you testified in *Davis* previously, correct?

A Correct.

Q And you testified in *Davis* that you never use it in your clinical setting. Do you recall that?

A I probably have started it using it a couple of times since then.

Q And *Davis* was in 2008, I believe?

A Was it 2008 or 2009? I forget.

Q Approximately. I'd have to go check. But, actually, we can grab it. It's actually 2009.

So just to recap, since 2009 you use it sometimes. Is that your testimony?

A Uh-huh. Yes.

Q You also testified -- actually, strike that.

In one of the slides, you refer to -- I don't think we went over it today, but Best Practices in Intellectual Assessment?

A Can you refer me to the slide?

Q Sure. Before I get into the slide, let me talk about *Davis* for a second. You testified in *Davis* about this -- the Best Practices in Intellectual Assessment then. You actually testified that it was an authoritative guide. And I can find that testimony, if you don't recall. Let me just find the slide that -- while I'm looking for that, I'll ask you about Social Security. You also testified that Social Security -- when determining Social Security, that actually a higher confidence level -- you have to use the lowest number, correct?

A Lowest of the three -- lowest of the variable, performance of full-scale IQ, correct.

Q But when they determine the IQ for Social Security, they don't use the Flynn effect, correct?

A I don't think so.

Q Now --
A But I think it would be very interesting to see what they would do if a psychologist reported it out.
Q Well, my question was simply whether they use it or not.
A I don't think they would reject it, but I don't know that they use it.
Q And you're guessing, correct?
A I don't know.
Q But you know that they don't use it currently?
A I don't know that either.
Q Okay.

Now, Page 57 of the slides -- I can put it on the ELMO.

So at the bottom, do you see that this quote came from the Best Practices of Intellectual Assessment?
A Yes.
Q And that's the Best Practices in School Psychology, correct?
A Correct.
Q Used by the -- in -- I guess the publication is the National Association of School Psychologists, correct?
A Right.
Q Now, that was in 2003, on the quote that you have here, because of the date down at the bottom, 2003.

Do you see that?

A Correct. Yes.
Q And you're aware that in schools today, the Flynn effect is still not used despite the fact that this was nine years ago, correct?
A Correct.
Q Now, let's go to the chart. Now, this chart, which, as I said, was part of -- that was Exhibit B, Defendant's Exhibit B. This is a little bit different than the chart that is attached to your report, Exhibit A, correct?
A Correct.
Q And you made a few changes from that, correct?
A I made a few changes, yes. And the reason why the changes were made --
Q Sure.
A -- if you want to know --
Q Sure.
A -- first of all, there were some math errors that needed to be corrected.
Q And these were math errors by Dr. Nagler; is that correct?
A No. These were mine.
Q Okay.
A For one of them, I multiplied by 1 instead of 2. And that's why there's a difference between the report that was submitted and this one. So this is the corrected version.

Q And the math, was that with the confidence intervals? Is that where you can see your math error?
A Yes. And it was -- what it turned out to be was -- the error was I used 60th percentile instead of 95th.
Q Okay. No problem.
Now, you also corrected a few errors, though, in the in the actual test scores from way back, correct?
A There was a typo in the Aranoff score that needed to be corrected, and that's documented there.
Q Okay.
And that was -- the performance IQ was actually -- you had it down as a 93, and it was a 90?
A Correct.
Q And you had the full-scale IQ as an 80 when it was a 78; is that correct?
A Correct.
MS. COHEN: Just one moment, your Honor. I will use my own copy with the ELMO, if that's okay.
THE COURT: What are we putting on the ELMO now?
MS. COHEN: I was going to put part of Dr. Aranoff's report that has the scores so we can compare them.
THE COURT: What page is that?
MS. COHEN: Yeah, sure. That is marked Government's -- or it's marked GOV 003995.
THE COURT: Is that in evidence?

MS. COHEN: It is not. This was something that the doctor relied on. I can lay a foundation for the fact --

THE COURT: Is there any objection to placing this in the record?

MR. BURT: No, your Honor.

THE COURT: Would you like to see it first?

MR. BURT: I've got a copy of it. Thank you. I appreciate that.

THE COURT: Do you object?

MR. BURT: No.

THE COURT: Do you move it into evidence?

MS. COHEN: Sure. I just wanted to refresh his recollection. I can move the whole report into evidence. That's fine.

THE COURT: Counsel didn't object to the page.

MS. COHEN: Yes, sure.

THE COURT: I don't know if he objects to the report. I just want to have a record that's complete so if there's judicial review at the appellate level some day, by chance, that we provide a clear record -- that's all -- of what was presented to the witness to review.

MR. BURT: Your Honor, it might speed things up if I at this point mark this set of documents that's being referenced because there's going to be other references to that set of documents.

THE COURT: That would be fine.

MR. BURT: We would move those documents in, and then counsel -- everybody would be on the same page.

THE COURT: "Those" meaning exactly what?

MR. BURT: These are the group of records that all the experts relied upon in forming their opinions.

MS. COHEN: That doesn't -- he's correct. I mean, I think all the experts -- these are all the prior IQ tests, all of the notes and the actual score of these tests. So we'll be relying on them as well.

THE COURT: All right. Let's give that an exhibit number.

MS. COHEN: All of the reports, your Honor?

THE COURT: Yes.

MS. COHEN: Altogether? That would be great.

MR. BURT: That's C-1-1, 1-2, 1-3, and 1-4. It's four volumes.

THE COURT: All right. Four volumes, C1-1 through -4 are received in evidence without objection.

(Defendant's Exhibits C-1 to C-4 were received in evidence.)

THE COURT: Go ahead.

MS. COHEN: Thank you, your Honor. The only problem is I don't know if this report is in C-1 or -- this is going to be C-4, and this is Dr. Aranoff's report.

THE COURT: And it's page?

MS. COHEN: The page I'm looking at is GOV 003995.

THE COURT: All right. Go ahead.

BY MS. COHEN

Q Now, Dr. Shapiro, I'm just showing you this because you made a correction that Dr. Aranoff -- you actually had the correct score of 93 -- it was not 90 -- and I just wanted to show you here this is Dr. Aranoff's report. And she says a verbal IQ of 72, a performance IQ of 93, and a full scale of 80.

So, in fact, your prior chart was really the correct one; is that right?

A May I see that, please?

Q Oh, sure. I'm sorry. This copy is highlighted. I'm only using this because of the problem with switching.

THE COURT: Well, if you want to show it to the witness --

Would you rather read the paper?

THE WITNESS: I do prefer the paper versus the screen.

THE COURT: Why don't you present it to the witness.

MS. COHEN: Oh, sure.

THE WITNESS: Thank you, your Honor.

THE COURT: You're welcome.

BY MS. COHEN

Q Have you had a chance to review it, Dr. Shapiro?

A Yes. What I'm looking at right now are GOV 564, 565, and 568.

Q You're looking at something else?

A Well, basically the pages I referred to there.

Q Oh, yes. Your chart now is still up on the ELMO.

A She has inconsistent forms. So it says that it was reported twice as 90 and once as 93. So I'm not sure which version you're using.

Q Okay.

A So if you can get the other two documents, then I think we can put this to rest.

Q Well, actually, I see. Is this what you're talking about? Let me put it up on the ELMO so everyone can see it, and then I'll bring it up, if that's more helpful.

The next page has "Earl obtained a low-average full-scale of 80 on the WAIS-III." There was a large -- oh, we can skip that and get to that later.

But his verbal IQ of 72 and then the performance IQ of 90. Is that where you got 90 from?

A Yes, ma'am.

Q But the 80 -- the 80 that you changed, did not change in that document. And I'll put it back there for a second. The full scale is still 80, not 78, right?

A And where is the third document?
Q The third page?
A No, there's a third document we refer to at the bottom of the chart. And that would be 549566 and -568.
Q Okay.
A And they're numbered differently than the numbers you gave me.
Q Okay. Let's just say it's fair to say that you can't tell for sure now, looking at it, if it was a full scale of 80 or a full scale of 78. Is that what you're saying?
A What I'm saying is she reported the PIQ twice as 90 and once as 93 on the documents that I had, and those are referenced there.
Q So did you do your own math and determine it would've been a 78?
A That was provided to me by someone I asked to look at the scores and reconcile the differences.
Q Okay. So you adjusted that based on the inconsistency in the --
A In her report.
Q -- performance IQ --
A Correct.
Q -- even though 80 was consistent throughout it, correct?
A No. Her full-scale IQ would've been 80 if you used the 93 and 78 if you used the 90.

Q Right. But it's also logical that the 90 could've been a typo since the full IQ didn't change on her report, correct?
A But it could've equally -- well, in fact, it would've been more likely that the 93 was the typo because she talked about the 90 twice.
Q Right.
But she talked about the 80 twice as well, correct?
A I'm also not sure that we're using the same set of records.
Q Okay.
A I will grant you what you're saying.
Q All right.
So let's talk about some of the other -- the only other change in your report, I think, that -- the chart in your report, other than the footnotes, was you noted that Nagler -- you made an adjustment there as well, right?
A Right.
Q And that was because there was an arithmetic error in her calculation, correct?
A Correct.
Q Okay.
A And as you pointed out earlier, this is not an uncommon finding, so it should not reflect on her competence.
Q Right, of course.
Now, in this column -- I'm pointing to the same

document now, your same chart from Exhibit B --

THE COURT: No, no. It's in Exhibit A.

MR. BURT: Correct, your Honor.

MS. COHEN: Oh, I'm sorry. Exhibit A. You're right, your Honor. I apologize.

THE COURT: Go ahead.

BY MS. COHEN

Q The norm here, that's significant because that's the year you use to determine the Flynn effect, correct?

A Correct.

Q And you used that year -- you subtract from the year it was taken from the normative year, right, the normative copyrighted year, correct?

A Correct.

Q And then you multiply those amount of years times .33, correct?

A Correct.

Q Okay.

Now, the WISC-III, the second test -- this WISC-R is correct. That was normed in 1972, 12 years later. So that's correct with the Flynn adjusted score. But the WISC-III, the normative copyright, was actually 1991. And I can show you the WISC-III. I can put it up on the ELMO, if that's helpful. This is the WISC-III manual.

THE COURT: Is this in evidence? Are you just using

it to --

MS. COHEN: I don't need to show the Court. I can just use it to refresh his recollection.

THE COURT: Does he have a recollection?

BY MS. COHEN

Q Are you aware that the WISC-III was copyrighted -- dated 1991 and not 1989?

A That may be true, but that's not when it was normed.

Q Okay.

And when it was normed --

A It's usually several years before the date that it's copyrighted.

Q Right.

But they usually put that the normative data copyright date, right?

A Right.

Q Okay.

So does it refresh your recollection that the WISC-III actually has a normative copyright of 1991?

A Okay.

Q It refreshes your recollection? Okay.

THE COURT: You have to say yes or no.

A Yes.

BY MS. COHEN

Q So, actually, instead of 1989, it was actually normed in

1991.

So Dr. Nagler's score -- I'm sorry. Dr. Drezner's score, which was taken -- the test was taken in -- which was taken in 1991, should actually -- this 1991 should actually go up a point, right, so instead --

A .6.

Q Right.

So instead of being a 77, this becomes a 78, correct?

A Correct.

Q Okay.

And this is the same for everyone else that used the WISC-III. So Aranoff would go up --

A It's all .6.

Q Right. So if we used a 78 -- and I'm sure others will disagree on that -- that would become 79. Under your changed full scale, would become a 77?

THE COURT: We're looking in the corrected FS IQ?

MS. COHEN: Yes.

BY MS. COHEN

Q Let's do this. I'm going to correct. This was 1991, the date of the test. The WISC-III came out. The normative year was 1991. So we don't take off as many points. We don't take off any points. It would be the same full-scale IQ of 78 that I had written over here. Actually, I shouldn't do that. It's

not Flynned over there. It just becomes a 78.

Dr. Aranoff's test was given in 1993. Now, 1993 would've been two years later, so it would be .6. So that comes out to a 79. Or if you use your other score, it comes up to a 77.

Now, Dr. Nagler -- her score would also come up a little bit, and that would come up to a -- well, on the new number, it would come up to a 69 for the full scale because, again, this date is 1991 and it was taken three years after. It was taken in 1994. So it would be 9 -- .9 points.

Now, we'll skip Dr. Frank, because he didn't do a full IQ; and we'll go to --

THE COURT: Is the witness agreeing with your calculation?

Are you agreeing with the calculation?

THE WITNESS: Yes, I am.

THE COURT: I just need that on the record.

MS. COHEN: Sorry. I thought I was --

THE COURT: You were stating it, but he wasn't agreeing to it.

MS. COHEN: Thank you, your Honor.

THE WITNESS: I'm sorry. I agree to the changes stipulated on the WISC-III.

THE COURT: All right. Let's move on.

BY MS. COHEN

Q Okay. Let's move on.

Just to be complete, so in 1989, Giglio's score would change to a 78?

A No. It would be 77.63.

MR. BURT: Your Honor --

THE COURT: Mr. Burt.

MR. BURT: Before we do move on, might I look at the publication that we started this point on?

THE COURT: Sure.

MR. BURT: If I could. Thank you.

BY MS. COHEN

Q Okay.

So you're saying it comes up to a 77.6 --

A Three.

Q Three, which is rounded off to a 77. But we could -- I'm sorry. Comes up -- it was an 80, so it comes to a 78.68, which is rounded to a 79, correct? We're using rounded? I wouldn't round your 77.03, but we're rounding a 78.6 to a 79; is that correct, Dr. Shapiro?

A I'm trying to understand where you're going with this.

Q Okay.

Well, I'm just making the changes so we're all on the same page.

A Okay.

Q All right.

So that's the WISC-III. Now --

THE COURT: Did you get an answer to that question? I didn't hear an answer. What was the question? The question was whether rounding to a 79 on the corrected FS IQ for --

MS. COHEN: We're putting it at a 78.63.

THE COURT: For the '98 test; is that right? Is that correct?

MS. COHEN: That's correct, your Honor.

THE COURT: And is the witness agreeing that that's a fair revision?

THE WITNESS: I think if we're using it as corrected full-scale IQ, that is okay, because IQ scores are reported as whole numbers.

The thing that I get concerned about is when you start doing adjustments on rounded numbers, but then you get a multiplicative kind of effect. So what I'm hesitating about is when you then go and use the confidence limits around the number, if the number's rounded up, then the confidence limits are going to move -- the changes in the confidence limits are going to be exaggerated.

THE COURT: My -- the Court's concern is that this -- the changes -- this is the witness' chart. If there are going to be changes in the witness' chart to which the witness agrees, then I think it should be presented to the

witness so that he can review it and indicate, through his -- through defense counsel, that he agrees with the changes, rather than doing it on the fly here in court. I think that's not fair to the witness.

So, you know, you have the changes that you propose; but I would ask Mr. Burt to review those changes and to submit an updated version of the chart, which the witness agrees is accurate.

MR. BURT: I appreciate that, your Honor. What I'm trying to figure out right now is the normative copyright date -- is that the date that norms were done. And I'm looking at a publication that says, in fact, the norms were done in '89. So I'm trying to figure that issue out.

THE COURT: Well, why don't you try to figure that out and then discuss with the witness whether those changes are appropriate, understanding that we can always bring the witness back for further questioning. I just don't want to present this -- I don't think it's fair to the witness to present it and do all these calculations in this setting. I'd rather have a more deliberative process. Okay, Mr. Burt?

MR. BURT: Thank you, your Honor. I appreciate that.

MS. COHEN: Thank you, your Honor. And you know what. We'll do that anyway.

BY MS. COHEN

Q And just to be complete, why don't we give this the 78.60 -- sorry. Your math, Dr. Shapiro?

A Sixty-three.

Q Sixty-three.

MS. COHEN: That's what the witness is agreeing to, so I don't have a problem with that. I'll put the 78.63.

BY MS. COHEN

Q Now, Dr. Shapiro, the normative date -- a lot of times they have to take a census first, correct, in order to get understand where they're going to get the norms from?

A Correct.

Q Right.

So the date of the census is not necessarily the norm date, correct?

A Correct.

Q Okay.

Now, the WAIS-III, that's the next test that was given by Dr. Popp and Dr. Drob, right?

A Correct.

Q Now, the WAIS-III, you have as normed in 1995, correct?

A Correct.

Q And the WAIS-III -- and, again, I can come up and show you this, but the WAIS-III has the normative data copyright as 1997. So that also would be 1997, not 1989; is that correct?

A May I see that?
Q Sure. (Handing.)
While I'm bringing this up, you got this data from Dr. James, who is going to testify later, correct?
A Correct.
Q And Dr. James testified with you in the *Davis* case, correct?
You can answer that afterwards. Go ahead.
A Normative copyright date here is listed as 1997.
Q 1997.
And, actually, Dr. James used the 1997 date in the *Davis* case. Do you recall that?
A No.
Q But the normative date in the book is 1997, so that would make sense, correct?
A Correct.
Q Now in 1997 we have to make a bit of an adjustment here as well? Again --
A It's also .6.
Q These would -- also .6. Right.
And these, of course, would be subject to approval later on. But just so we know what we're talking about for purposes of cross, it would come up to an 83 point -- well, as long as I'm not changing it to an 84, we're okay, right?
Okay. Now -- is that a yes?

A If you add .6 to 82, it's 82.95.
Q Oh, okay. I'm sorry. I'm not adding as well.
Now, Dr. Drob -- instead of being a 73.36, would come up to a 74, correct?
A Or a 73.96, if you want to be precise.
Q Right.
Now -- okay. So those scores, they change a little bit, but we can go into that later. It does affect it, based on the normative years, correct?
A By about a half a point.
Q Right. Okay.
Since we're being entirely accurate, we want to make sure it's accurate, correct?
A Right.
Q Now, if you take -- let's just for the moment take the scores without using the Flynn effect just for the moment. Okay, Dr. Shapiro?
A I'm listening.
Q You understand? Okay.
So we're going to look at the "full-scale IQ" column. And the only score that is close to 70, or 70, or reaches the -- with confidence intervals, reaches the below-70 is the Nagler score, correct?
A Correct.
Q Here, right?

Now, Dr. Nagler, by the way, was the only doctor who the defense wasn't able to -- the defense team wasn't able to speak to in this case, right?

A I don't know the answer to that question.

Q Okay.

Well, actually, Dr. Nagler, unfortunately, is no longer living; so they were not able to speak with her, of course.

Now, I assume, though, in looking at this, that you looked at her notes, correct?

A Correct.

Q And her notes are important because that shows clinical judgment, correct?

A Clinical judgment would be contained in the report, yes.

Q And clinical judgment is essential, right, to looking at an IQ score, correct?

A Correct.

Q Because if you don't -- you said previously in *Davis* -- you said if you don't look at clinical score, you're really on thin ice, right?

A Correct.

Q And the reason -- one of the reasons why clinical judgment is important is because you want to know what the test taker was like on that particular day, correct?

A Correct.

Q All right. So, for example -- I guess this is an extreme example. If the person was drunk, you'd want to know that, right?

A Yes. It's an extreme example.

Q It's an extreme example, right?

That would affect the person's taking of the test, right?

A Yes.

Q You would also want to know if the person fell asleep during the test, correct?

A Yes.

Q You'd also want to know did the test taker think they were malingering, or not giving a full effort, right?

A Yes.

Q Now, Dr. Nagler -- her notes -- and this is --

MS. COHEN: Again, I believe this would be in C-4, Mr. Burt, if this is in order of the test takers. That would be correct, right?

MR. BURT: Yes.

MS. COHEN: Of the dates of the test? Thank you.

BY MS. COHEN

Q Sorry.

This would be in C-4. And I am referring to Government -- GOV 003941. Her score -- her test goes all the way up to 3977. And that's because Dr. Nagler not only

included her notes but she has the raw data there as well, correct?

A Correct.

Q Dr. Nagler -- as, actually, we'll see all of the psychologists in this case were -- was very thorough in her notes.

Are you aware of that?

A Aware of what?

Q Sorry?

A Aware of what? That she is thorough in her notes?

Q That she was thorough in her notes. I can show them to you, but she made four pages of notes here.

A Can you tell me which pages to which you're referring?

Q Sure.

There are two Bates numbers on this document. I was referring to GOV 003941. There's also an "RW" stamped at the top. So I'm not sure which one you're looking at.

A I have that one.

Q You have the RW?

A The 003941.

Q 41. Okay.

And that's the front page where she talks about what her test was, correct?

A Correct.

Q And then the second, third, fourth, and fifth pages, it

goes from GOV 003942 through 3945. Those are Dr. Nagler's notes, correct?

A That is her report.

Q Her notes and her report. Okay.

And in her report, she noted on page -3942 that he utilized -- and I'm reading from the second paragraph. "Earl squirmed and placed his fingers in his mouth. He yawned continuously. He blurted out responses and generally utilized a cautious, impulsive approach."

And that note -- that's important, right? Excuse me. I'm sorry. That's a "careless," not "cautious" -- a "careless, impulsive approach."

A Could you read the next sentence, please?

Q "Nevertheless" -- well, actually, let's just stop there for a moment. "He yawned continuously. He blurted out responses and generally utilized a careless and impulsive approach."

So my question is: That is important information, correct?

A It's a clinical observation, correct.

Q Right.

A And it may be important, yes.

Q And that --

A It may be important, yes.

Q It may be important because it talks about the test

taker's effort, correct?

A Yes.

Q Now, the other score -- okay. So that was looking at just Dr. Nagler.

So now we go into the Flynn world. We also look at Dr. Drob. And, actually, in your report, Dr. Drob's IQ score is the one that you rely on, correct?

A Correct.

Q Now, Dr. Drob -- by the way, you had testified earlier, when you were talking about how you got involved in this case; and you said one of reasons you got involved is because you were generally local, right?

A That was in *Earl Davis*. I am not local here.

Q Oh, okay.

But you're aware, actually, since -- I'm sorry. You're right. That was Dr. Davis, because that's where the trial --

A The trial was in Maryland.

Q Right.

So that was local.

A It was much easier getting there than here.

Q Right.

And Dr. Drob -- he's actually a local psychologist, correct?

A I don't know Dr. Drob, so I can't tell you.

Q Well, Dr. Drob was the one -- it was 2003 when he did the IQ, correct?
A Correct.
Q And you don't know Dr. Drob, but Dr. Drob -- he's a psychologist in the area.
A I'm sorry. Which area?
Q He's a psychologist.
A Which area?
Q In the New York area.
A Okay.
Q Okay.

And he was called in in 2003 to perform this IQ on Mr. Wilson after he was arrested in this case. You're aware of that, right?

A Correct.
Q And Dr. Drob -- Dr. Drob's credentials -- I assume you saw his report in this case, correct?
A Yes.
Q And he's a prominent psychologist in the area. He testified many times before. Are you aware of that?
A No.
Q Okay. But he was hired in this case by the capital defenders.

Are you aware of what the capital defenders do?

A No.

Q The capital defenders' work is entirely devoted to capital work, which makes sense, right, based on the title? So you're not aware of that?

A No. I didn't know there was such a group.

Q Are you aware that Dr. Drob was hired by the capital offenders [*sic*] at the time that this case was being prosecuted by the Staten Island D.A.'s office?

A No.

Q And at that time, are you aware that the Staten D.A.'s office was making a determination as to whether or not to seek the death penalty. Are you aware of that?

A No.

Q And Dr. Drob, are you aware -- of course, this was 2003. This was after *Atkins*, correct?

A Yes.

Q So Dr. Drob was hired for that specific purpose in this case. You're aware of that?

A No.

Q And you're aware, however, that he did not find Mr. Wilson to be mentally retarded, correct?

A He called him "borderline." He called him borderline, intellectually limited.

Q He did not find a diagnosis of mental retardation, correct.

A Correct.

Q And you're aware that Dr. Drob did not testify in the 2006 proceedings, right?
A No.
Q You're aware that there was no *Atkins* hearing in the 2006 proceedings, correct?
A I'm totally unaware of the earlier proceedings.
Q Now, Dr. Drob in his report -- he did not apply the Flynn effect, correct?
A Correct.
Q And he noted in his report the discrepancy between Mr. Wilson's verbal comprehension index and his perceptual organization index, right?
A Yes.
Q And Dr. Drob noted that that's highly suggestive of a specific learning disability in the verbal sphere, right?
A He noted that, yes.
Q He also noted that Mr. Wilson had a higher intellectual potential or intellectual functioning, right?
A He speculated on that. I'm not sure what data he used to support that conclusion.
Q Well, he was the test taker in this case, right?
A He was the test --
Q The test provider or test giver, right?
A Correct.
Q And as the test giver, he's the person who's making the

clinical judgment, based on what the test taker is doing, right?

A Correct.

Q And clinical judgment, you already agreed, is critical, correct?

A Yes.

Q And Dr. Drob met with Mr. Wilson not only to give him the IQ test but he met with him for several hours. Are you aware of that?

A No.

Q And he also -- getting at the fact that he saw a higher intellectual functioning, he said that the -- that range between the normal range and the higher scores on the two nonverbal subtests -- he specified that -- suggested a higher intellectual potential than his cognitive functioning has been, and that has been compromised by his learning, correct?

A He said that, yes.

Q Now, he also specifically talked about his poor scores in tests of immediate memory and free verbal recall, right? And this is on, if you need to refresh your recollection -- do you recall that?

A I'm reading along with you. Can you refer me to the page number?

Q Okay. It's GOV 004028.

A Which paragraph are you talking about?

Q The fourth one down.
A I'm sorry?
Q The fourth one.
And in that fourth one, he noted poor scores in tests of immediate memory? That's a subtest in the IQ, right?
A We're talking about digit span, yes.
Q And free verbal recall, right?
A Yes.
Q That's another subtest?
A It's not called that. It's one of the subtests, yes.
Q And those are commensurate with the hypothesis of a learning disability, right?
A Yes.
Q And that these deficits are often seen in individuals who are diagnosed with attention deficit disorder, right?
A Yes.
Q Now, the subtest matrix reasoning, that subtest is one of the ways in which you -- you test an individual's abstract thinking. Is that one of those tests?
A Yes.
Q And the picture arrangement, is that one of those tests?
A Picture arrangement is being able to put pictures together in a way that tells a story.
Q And does that call on some of the reasoning we talked about earlier?

A It calls on a number of things. It calls on executive functioning, it calls on language abilities s. It calls on being able to forecast how things go so you end up with a logical conclusion.

Q And picture completion, is that similar?

A No. Picture completion is just what's the missing part.

Q Okay.

Now, let's talk about -- getting back to the notes that we talked about with Dr. Drob. Those notes we just went through, those are very consistent with all of the notes from the test -- is it the test provider, Dr. Shapiro, the ones giving a test? Is that the term you use? I just want to make sure we're using the same term.

A Administrators.

Q Administrating -- thank -- administering.

The test administer -- administrator, all of these psychologists in this case -- all of them had similar comments to Dr. Drob, correct?

A They all recognized the fact that Mr. Wilson had asynchronous development.

Q Had -- I'm sorry?

A Asynchronous development, that there was a discrepancy between his verbal and his performance abilities, correct.

Q Well, in 1989, when Wilson was 6 years old, Dr. Abramson said that he also had higher intellectual potential, correct?

A Yes.
Q And that it was the emotional problems going on that lowered it, right?
A Well, he had -- he confronted a child who had behavior problems and cognitive problems and he found an association and then he wrote the causality in one direction and could equally well have been run in the other direction.
Q Okay. My question, simply, is she --
A So that instead of his bad behavior depressing his IQ, his IQ could have been responsible -- or cognitive dysfunction could've been responsible for his behavior disturbance.
Q Right.

And Dr. Abramson said -- or -- yes, Dr. Abramson said -- and this is from Government 003925. These are Dr. Abramson's notes. "Summary: Earl is functioning below his potential intellectually, in the low-average range. Emotional concerns interfere with his academic and social functioning."

And so my question is: It touches on some of the same things that Dr. Drob said, correct?
A No.
Q Well, it touches on the fact that his intellect is higher, is potentially higher, correct?
A It said that interfered with academic and social functioning. She did not make a statement about his cognitive

functioning.

Q Right.

But it did say that he was functioning below his potential intellectually, correct?

A Yes.

Q Now, Dr. Drezner also said that the score was depressed, right? And I can refer you to GOV 003932. "Earl's borderline IQ of 78 appears depressed as a function of emotional and cultural factors. Earl's true cognitive ability appears to be in the low-average, average," right?

A That's what she said.

Q Right.

A May I expand on that, though?

Q I'm just asking you if that's what she said.

A Then, that's what she said.

Q And Dr. Aranoff said that depression and other emotional and adjustment problems and language deficits were causing the score to be depressed, right?

A Correct.

Q And Dr. Nagler, we already went through.

And Dr. Giglio said that the difference in scores, the 25 points, between verbal and performance -- that that was the basis for his end conclusion that Mr. Wilson had a learning disability, right?

A Correct.

Q And, now, Dr. Popp -- he also said that Mr. Wilson had the potential to function in the mainstream, right?
A Correct.
Q And that because -- that his verbal was lower, right? And that -- is that correct?
A His verbal was lower. Yes, he said his verbal is lower.
Q And that he had to rule out academic and cultural deprivation, right?
A I'm sorry. You're going to have to refer me to the page number.
Q Sure. Page GOV 004024.
A Thank you. Which paragraph?
Q Under "educational implications."
A Okay.
Q "The available information." Do you see that?
A I've got that. Okay. Yes, he said that.
Q And then it was also recommended that Ronell aim for class grades that are substantially higher than the average student's, right?
A Yes, he said that.
Q Okay.

Now, Doctor, in 2003 the defense also hired, in addition to Dr. Drob, another prominent psychologist, right?
A I don't know.
Q Dr. Yates' material was included in this material, right?

A Dr. Yates?
Q Dr. Yates.
A I'm sorry. I don't remember seeing that.
MS. COHEN: Mr. Burt, is Dr. Yates part of that; or should I mark it separately?
Sorry, your Honor.
MR. BURT: Yes.
MS. COHEN: And it's in C-4?
MR. BURT: Should be in C-4.
BY MS. COHEN
Q And in Exhibit C-4 is information from a Dr. Kathy Yates. And I'm referring to Exhibit GOV 010521.
A I don't have that.
Q You never saw a record from Dr. Kathy Yates, right?
A I don't have any recollection of that one.
Q Okay.
Well, it would be important, right -- in concluding whether someone is mentally retarded, it would be important to look at the entire record, correct?
A Yes.
Q And it would particularly be important when a doctor is specifically hired for the sole purpose of finding whether or not someone is mentally retarded -- it would be important to know what the result of that finding is, right?
A Depending on when the evaluation was done, because as we

have testified before, people with intellectual disability can improve. And, consequently, I think it was appropriate that when the Court order came down, it talked about the time proximate to the crime as to whether or not Mr. Wilson was intellectually limited at that time. So if it was close to that time, then the answer to your question is yes.

Q Well, this is actually a doctor who you reviewed records and formed an opinion at the same time as Dr. Drob in 2003.

MR. BURT: Judge, I have not objected up to this point; but a lot of these questions are factual statements, like the one that she just asked. And the form of that question is improper. She's asserting factual contentions here that are outside the scope of this witness' knowledge, and she's not asking whether he agrees. She's making a statement of fact and then asking another question, and that's not proper.

MS. COHEN: I'll rephrase, your Honor.

THE COURT: All right.

BY MS. COHEN

Q Okay.

My question -- you had answered yes to the question of it's important to look at the entire record, right?

A Correct.

Q You agreed that it's important to look at what a psychologist determined, who was specifically hired to

determine whether or not a person was mentally retarded. Would that be something that was important to you?

A It would be important to see the whole record, and whether or not the person was hired for a specific purpose or not is not really all that important, because it's important to see the whole record.

So once you've set that, the details in terms of why that person came to do that evaluation, to me is not all that important.

Q Okay.

Let's talk -- let's move, then, to the category where you talk about one of the problems with the diagnosis of mental retardation is that people tend to underdiagnose it because of the stigma. Right?

A Among other reasons, yes.

Q Let's pull up your slide here in this case, Slide 33 and 34. Let's start with 33. Oh, we can't switch it -- I forgot -- on the ELMO. So Exhibit -- I'm sorry -- your PowerPoint, Lack of an Earlier Diagnosis of MR/ID?

A What's the number on that, please?

Q The page number is 33.

A Thank you.

Q And these are the reasons why someone who has mild mental retardation might not get an earlier diagnosis, right?

A Correct.

Q And the first reason is the individual was excluded from a full school experience, right?
A Correct.
Q And Mr. Wilson, however -- that prong, or that part, does not apply to him, right?
A Correct.
Q He wasn't excluded from the school experience, right?
A Well, until he got further along in his schooling. His early schooling is -- no, he was not denied a full school experience early on.
Q Okay.

Because we have records from him all the way up through high school, right?

A There were times that he was in another setting and then there were times when he was in a night school setting/alternative setting when he was in Redding, Pennsylvania. Then I think -- I don't know enough about it to say if that was a full school experience or not.
Q Okay.

But there was no evidence that he was excluded, meaning they weren't going to let him in, right?

A Correct.
Q Okay.

Now, the person's age precluded their involvement -- this is under B here --

A Uh-huh.
Q -- in specialized services, such as special education programs. That's another reason, right?
A Correct.
Q And that wasn't in this case, correct?
A That's correct.
Q All right.
Because Mr. Wilson was put in special education programs, right?
A Correct.
Q Now, C, the person was given no diagnosis or a different diagnosis for political purposes. Now, one -- or to avoid stigma or teasing.
Now, Mr. Wilson -- when he was in special education programs, he was still not diagnosed with mental retardation, right?
A Correct.
Q And there wouldn't be any stigma in changing his class within the special education program, correct?
A No.
Q Not correct, is what you're saying?
A Correct.
Q So if he's in the class for emotional disturbance, right, moving him to another class for people with mild mental retardation, or mental retardation, would be a stigma. That's

your testimony?
A Yes.
Q Now, Mr. Wilson was also tested outside the school, correct?
A Are you referring to the time he was at Elmhurst?
Q Yes.
We have two times. Dr. Abramson and Dr. Aranoff were in hospitals, correct?
A Correct.
Q And you would agree with me that hospitals don't have the same concern. Let's assume that you're correct, that schools were concerned with it.
The hospitals surely weren't concerned with it, correct?
A No.
Q Your testimony is that the hospitals were concerned with it?
A Correct.
Q And that a hospital would not diagnose someone as mentally retarded, because they wouldn't want to give him a stigma. Is that what?
A I think that the third part of that statement up there is probably the one that we should be talking about.
Q This one that we're focused on right now, right?
A The potential benefits of a particular diagnosis.

Q Okay.

In other words, Social Security?

A No. What not thinking about there is, for example, if you -- for example, if you defer the diagnosis of intellectual disability and use the diagnosis of autism, you are likely to get more special education services in most jurisdictions than if you were just to use the diagnosis of intellectual disability alone. So there might be reasons for using one diagnosis as opposed to another.

And the other thing that we speak to is the issue of self-fulfilling prophesies. People are very loath to say that somebody is not capable, because then people tend to perform to that level. So then you avoid using that. And so it's not uncommon to see children who are functioning, who meet criteria, even full criteria, for intellectual disability being called "learning disabled." So I think that's something we see.

The final point is the issue of diagnostic overshadowing where one diagnosis is just so much front and center that people are so focused on that that they neglect the other kinds of issues that are going on. And I think to some degree that was operational in Mr. Wilson's case. People were so focused on his terrible behavior that they were dealing with him from an emotional standpoint and not thinking about him from a developmental standpoint.

Q So they were so focused, all eight of the people who looked at him?
A Well, these were people who worked in mental health facilities and were people who -- in terms of his educational placement, this was an educational placement for severe emotionally handicapped.
Q But, clearly, the two people hired to get him off of the death penalty -- those people would not have the same concerns of stigma, right?
A Correct.
Q In fact, that would be just the opposite, right? Right?
A You can make a case that that was the case. I couldn't make any assumption about people's motivations who I don't know.
Q Right. But if that was -- if they were hired for that purpose and did not find mental retardation, you could not make the same argument that there was some -- they were worried about the stigma or political purpose?
A Right. We're talking about an earlier diagnosis. You know, we're talking about in younger children, primarily, here.
Q Okay. So when the diagnosis was done in 2003, you're saying that this wouldn't apply, right?
A Correct.
Q Okay.

Now, in addition, you talked about -- one more point on this -- the potential impact on benefits, right? You mentioned that -- is that correct?

A Yes.

Q Do you remember that?

A Yes.

Q You mentioned special education programs, right?

A Correct.

Q Mr. Wilson was already in special education programs, correct?

A Right.

But there are an increased level of services for children who carry the diagnosis of autism over those who carry the diagnosis of intellectual disability.

The other thing that you should know that also goes along with this C criteria is that the IDEA, the Individuals with Disabilities Education Act, recognizes a category called "developmental delay," which obviates the need for making the diagnosis of intellectual disability before age 8 in children, which would be another thing that leads to delayed diagnosis.

Q Right.

So, in other words, you mean that people would often not diagnose it until later, right?

A Because they would want to give the child the benefit of the doubt.

Q Right.

And another reason for that, you explained earlier, sometimes you see it more because as children are progressing, the person with mental retardation isn't progressing at the same level. Is that something you mentioned?

A They progress more slowly, typically, yes.

Q Right.

But in this case in 2003, you can't make that argument, correct?

A I'm sorry. I don't understand the question.

Q You're saying that's when they're younger.

But if you make the diagnosis in -- forget -- I mean, we've got 17 here. We've got 21 1/2.

A Those are not early diagnoses at that point.

Q Right.

Now, A couple more slides. Only a couple more questions on the IQ. Then I have some adaptive-functioning questions.

MS. COHEN: Is that okay, your Honor?

THE COURT: You go right ahead.

MS. COHEN: You tell me if you want me to stop.

THE COURT: Don't worry about it. I'll let you know.

MS. COHEN: Okay.

THE COURT: Let me ask the defense. Is it all right

to go ahead beyond 7:00?

MR. BURT: Certainly, if that's okay with the Court.

THE COURT: It's okay with the Court.

Go ahead.

MS. COHEN: Okay.

BY MS. COHEN

Q All right. So we'll continue using the ELMO. Let me just pull these, just so we can get on the same page while I'm looking, Dr. Shapiro. Page 9 of the slide --

MS. COHEN: And I'll put it up on the ELMO for everyone as well, so we're all on the same page.

BY MS. COHEN

Q This is the slide where you were talking about improvement, right?

A Correct.

Q And this really -- actually, I just realized -- I think we already touched on this, that there are certain things that are -- mentally retarded individuals can improve on and certain things they can't, correct?

A There are -- what this is speaking to, in my interpretation of this, it's speaking more to the adaptive-function part of the -- prong of the diagnosis --

Q Okay. Right.

A -- as opposed to the cognitive prong.

Q Right.

A But I have seen changes in the cognitive prong, in my clinical experience, in both directions. Sometimes people get worse and they grow into the diagnosis, and sometimes people get better and they grow out of the diagnosis.

Q Right.

But IQ basically doesn't really improve, correct?

A Wrong.

Q You think it improves? And what does an improvement in IQ show?

A I don't understand the question.

Q Does that show that someone has learned their way out of mental retardation?

A What it shows is that their performance on an IQ test has changed substantially. And that may have to do with neuro maturation. And these are mechanisms about which we know virtually nothing at this point in time. We don't know the brain mechanism as to why people are intellectually limited. We have a lot of associations, but we don't know the reason why.

Q Okay.

But there are -- we talked earlier about other parts of the IQ -- like, reasoning is very difficult to improve, right?

A Correct.

Q Okay.

Now, going back -- speaking of improvement --
A When you say "improve," I mean, I would like to have some sort of degree around that --
Q Sure.
A -- because you'll see some change, and it may be somewhat better. But the way I assumed your question was fairly marked and changed.
Q Broad, right.
You don't become an abstract thinker all of a sudden, right?
A Correct.
Q Okay.
Since we were talking about improvement, let's go back to the other -- I think you had a slide on it, but you talked about practice effects, right?
A Correct.
Q And you said that practice effect is most notable in the performance IQ, right?
A That's what the data show, correct.
Q Right.
And in this case, you would agree that in 1989, the very first time that Mr. Wilson took this test, there was no issue with practice effects, right?
A He did not take the same test.
Q My question is, In 1989 there was no concern about

practice effects, no matter what test he took, right?

A Correct.

But he was at the very bottom of the WISC score, so the amount of behavior he had to show was not very much. I probably would have recommended that the psychologist use the preschool version of the WISC, the WPPSI, for a child that age. Again, more behaviors so that you have a better feeling in terms of what his abilities are.

Q Okay.

But my question simply was: There's no issue with practice effects in 1989, right?

A That is correct.

Q Okay.

And under your reasoning, in 1991, when there was a new test, the WISC-III -- right?

A There was a new version of the WISC, correct.

Q It was the first time Mr. Wilson took it, right?

A Correct.

Q So under your reasoning, there would be no issue with practice effects in that case either, right?

A No.

Q Okay. And that is a --

A I said no.

Q Yes, I heard you.

A Okay.

MR. BURT: Excuse me. I think there's an ambiguity here. No, he does not agree with her or no, there was no --

A I did not agree with your statement.

BY MS. COHEN

Q Oh, I'm sorry. I thought you were saying -- thank you for correcting me.

A No.

Q I thought that you were saying no, there's no issue with practice effects.

A No, your statement was not correct.

Q Okay.

And that's because you can gain practice effects no matter what the test is, right?

A That part is yes. But there's also the other part, which is that parts of the WISC-III and parts of the WISC-R are very similar, if not identical.

Q Okay.

And the things that you do in the practice -- in the performance IQ, those subtests -- while they may change, you can learn them a little bit, you're saying, because they have similarities, right?

A Right.

Q Okay.

So even though you're saying there are different tests, that practice effect is still there, right?

A Yes.
Q Okay.
A I mean, the example that you may want to use from a more general population is, otherwise, why would children take SAT prep courses? The test is not the same, but they're basically learning the form of the questions.
Q They're learning the concepts, right?
A The form of the questions, in blank questions.
Q Okay. Right.

And in this case, from 1989 to 1991, the performance IQ went down, right?

A His verbal IQ also went down. And I think that what happens is that between the ages of 6 and 9, which is when those two tests -- when the test becomes much more difficult, which gets into the issue we talked about before in terms of floor effect --
Q Okay.
A -- not having enough behavior samples at the very beginnings.
Q We're just now focusing on the practice effects on the performance IQ. Okay? So let's just stick with that.
A Okay.
Q All right? Because that's what you already said: You see it mostly in the performance IQ.
A Uh-huh. So if you wanted me to say where, in example,

the practice effect would be, it would seem, to me, that if you looked at Drezner versus Aranoff, you would see substantial practice effect where performance IQ went up 12 points.

Q Okay. So there we see it.

Okay. Now you look at Nagler in 1994. Now that he's taken this, this is the third time he's taken the WISC-III, right?

A Correct.

Q And that goes way down, correct?

A Correct.

Q Goes back to down to 80?

A Back down to where it was.

Q Right.

So there was no -- there was no practice effect in that case, right?

A The practice effect may not have been long-lived.

Q Well, and, also, we have notes that suggest Mr. Wilson probably wasn't giving his best effort, right?

A He was -- was this the one where you said he was yawning?

Q Yes.

A So, yes, he may have been.

Q Right.

Actually, I just remembered something that gives us a little bit more of a window into that.

This is important because Dr. Nagler, as we said, unfortunately, is no longer living; so we can't ask her these questions.

THE COURT: Try not to embellish. Just ask the question, please.

MS. COHEN: Sure, your Honor.

BY MS. COHEN

Q Part of her report, GOV 003949 -- do you see that note there?

A "Blurted out answer"?

Q "Blurted out answer," right. And "blurted out answer" suggests that Mr. Wilson wasn't really thinking before he gave the answer, correct?

A What was the number again? I'm sorry?

Q I can put it back up. GOV 003949.

A Yes. She credited him for that answer.

Q Right.

And going a few pages more back, one more point, GOV 003954 -- this is again C-4. See this note where my pen is? That says, "Yawn, head on desk." Do you see that?

A Yes.

Q So that also could account for lower scores in that instance, right?

A Well, that's one interpretation.

Another interpretation may be that he topped out,

because he didn't get very much after that. So he may have reached his max there and checked out at that point because he couldn't do anymore.

Q Right. Okay.

So that practice effect -- there was no practice effect, is one point we agreed on, right?

A Well, the practice effect from the previous one may have been -- I'm sorry. Could you just let me see the dates in terms of when --

Q Sure. I'm sorry. Let me go back.

A -- it was administered?

So in terms of timing, the one from 11-6 to 12-7, or 9-7 to 11-6, was basically two years; and then the next one was a year. Okay.

Q Okay.

So what we established in 1994 is there was no practice effect, right?

A Presumably, yes.

Q Okay.

And then in 1998 with Mr. Giglio, it's a different test, right?

A No. He gave the WISC-III in 1998.

Q Oh, right. It's the same test, right.

Anyway, you said that didn't really matter, right? In other words, practice effects were still there.

A They may well be there.
Q Okay.
So the WISC-III for -- under Giglio got a performance IQ of 95, right?
A Correct.
Q And then it also stayed in the 90's with Dr. Popp. I'm sorry. Dr. Popp was a new test, the WAIS-III?
A Correct.
Q But, again, as you said, practice effects could still be there, right?
A Potentially. But, also, because he's -- again, he's at the bottom of the test. The WAIS starts at age 16. So he may have had insufficient behavior to measure on that test, which may have given him a somewhat higher score. And the WAIS probably, at the lower age range, probably does measure a little bit higher, because it's not uncommon to see people go up at some points when they move from the WISC to the WAIS --
Q Okay.
A -- at least as far as the WAIS-III was concerned. I don't know about the WAIS-IV.
Q Okay.
Well, let's stick with the WAIS-III. In 2000, performance IQ is 92. And three years later, Dr. Drob gives the same test, right?
A Correct.

Q And that goes down to an 85, right?
A Right.
Q And the WAIS-IV, given by Dr. Denny, is a new test; and that goes backup to 92, right?
A Correct.

So one of the questions that you would need to resolve, which I can't give you the answer for, is: Is there a difference between the behavioral expectations over 21 versus under 21 on this test?

For example, the WISC changes over. When it first starts off at the very low end of the WISC, the score is more generous. Then as the children move toward ages 8 or 9, it shifts over and becomes more severe.

And I don't know whether there's that kind of change in the WISC-III -- WAIS-III or not. That's something I just can't let you know or not.

Q Okay.

But when we look at this, we can't really tell anything -- there's really no consistent practice effect throughout his testing, right?
A Correct.
Q And by the way, his scores are pretty much consistent. I mean, we've got the couple that dropped down; but we're around the same range through all of his tests, right?
A Which set of numbers are you looking at? I'm sorry.

Q We can look at the full scale. I mean, whether you want to look at Flynn or the full scale -- I mean, we're not talking about great disparities between tests overall, right?
A There is a similarity in scores. I will grant you that.
Q Okay.
Now, going back, I just had a couple more questions on the slides. Slide Number 10, valid assessment, considers cultural and linguistic diversity, is Slide Number 10, right?
A Okay.
Q Now, in that slide is when you gave the example of Ellis Island. Do you remember that example?
A Yes.
Q And the reason you gave that example is somebody coming from another country might could seem that they fall into the -- or the fact that they don't understand our culture might be the reason why they were diagnosed something instead of being diagnosed mentally retarded.
Is that what you meant by that?
A Well, the example I gave when I talked about this slide was the parent I was talking to and the father was Hispanic, and speaking Spanish; and when I spoke back to him in Spanish, she said, "Why are you talking to him in Spanish? Because his English -- his Spanish is no better than his English."
And that was the example of not letting the cultural linguistic diversity overshadow and minimize the actual

disability.

I used the Ellis Island slide, I think, earlier than that --

Q Okay.

A -- which basically said that you had be appropriate, but the other thing is that you also have to be sure that you don't explain it away solely on the basis of cultural linguistic diversity and thereby miss the disability.

Q Right.

You can't explain -- and I guess what I'm going to draw your attention is -- sometimes you can't explain it away entirely or solely, you said, on the culture in many instances, right? That's just to rephrase what you said?

A I think you need to be careful when assessing children with different linguistic backgrounds or different cultural backgrounds, to make sure that you're not attributing their low function on testing to their cultural linguistic, but you also have to be sure that you're taking that into account so that you're not overcalling in the other direction either.

Q And actually -- that was actually my point, that it can very much affect it, right? The cultural issue could very much affect the IQ, right?

A Yes.

Q And it could in some instances be the reason for the lower score?

A Yes.

Q And now slide Number 11, the next slide -- and this is good because it's sort of going into the adaptive-functioning area, which is where I want to go.

But "Individuals with intellectual disability typically demonstrate both strength and limitations in adaptive behavior. Thus, in the process of diagnosing ID, significant limitations" -- and we've already been through them. I'll try to skip over -- "is not outweighed by the potential strengths."

My question is that it is also true that the converse exists as well, right?

A Tell me what you mean by "the converse."

Q Okay.

And what I mean by "the converse" is that it could be that somebody's strengths so outweigh the deficits that that person can't be intellectually disabled, right?

A What this is saying is that people who have -- people with intellectual disability have patterns of strengths and challenges, and just because they have strengths is no reason not to make the diagnosis of intellectual disability --

Q Right. I understand that.

A -- if they meet criteria.

Q Right.

But I'm just -- my point on that is that it could be

that somebody's strengths -- in other words, if I only have -- my deficit is small in comparison with all of my strengths, that the converse would be true that, if that was the case, there were so many strengths, they could also outweigh the deficit in some instances, right?

A I'm trying to think of a clinical example, but I'm having difficulty.

Q Well, I guess one reason -- I mean, under the DSM, if you have the ten categories, right, and let's say this person only meets -- well, first of all, if you only meet one, you're out, right?

A One of the three?

Q Well, one under the AAIDD --

A Correct.

Q -- or two of the ten under the DSM, right?

A Correct.

Q So let's focus on the DSM for a second.

If you have all of the strengths, let's say -- you have two categories with deficits and you meet all the strengths, but if the deficits are so minor, there could be a circumstance where you might say, "You know what. This person is not intellectually disabled," because you have to take the whole picture into account, right?

A You need to take into account that the deficits are impairing. Otherwise, they're not deficits.

Q Right. Okay. Now --

THE COURT: About how much more do you have for this witness?

MS. COHEN: I have probably an hour.

THE COURT: An hour? Well, if that's the case -- I could stay until midnight; but I don't think it's fair to the defendant, who has to go back to the MDC, and the marshals, who have to take him there, to keep anybody here past 8:00.

But if you've got an hour, and then there's got to be redirect, you know, I think that we're way beyond where we need to be.

Mr. Burt, do you have any views on it? I mean, I'm willing to stay; but I'm a little concerned. Plus, we have a witness -- although he'd love to leave, it's not fair to him either to keep him here all night.

MR. BURT: Right.

THE COURT: What is your wisdom, Mr. Burt?

MR. BURT: My only difficulty -- I would prefer to break now for a lot of reasons. But I would also, if I could, ask Dr. Shapiro whether that's workable for him, because if it is, my preference would be to come back.

THE WITNESS: It would be far, far easier for me to stay. I'm okay, Judge. Thank you for your concern.

THE COURT: Let me ask the marshals: Does this create a problem for you?

THE MARSHAL: Whatever you want, Judge.

THE COURT: All right. We'll just keep going, then.

BY MS. COHEN

Q Okay. And when --

THE COURT: Hold on. Relax.

MS. COHEN: Okay.

THE COURT: When you say stay, you mean stay on the witness stand?

THE WITNESS: Yes.

THE COURT: I thought that's what you meant.

I just wanted to clarify that with the witness.

All right. Let's take a five-minute recess, and then we'll return.

(Recess taken.)

MS. BRADY: Your Honor, may we come up for a moment at sidebar?

THE COURT: Come on up.

(Sidebar begins.)

(Continued on the next page.)

MR. STERN: Judge, only reason we wanted to come up is Mr. Wilson doesn't get breakfast.

THE COURT: That's why I said what I said.

MR. STERN: Now he's not going to get dinner.

THE COURT: I was looking at Mr. Wilson. He's Wilting. I want him to be alert. I know the food situation is what it is. And, if necessary, he doesn't have breakfast, we'll get him breakfast, if that's necessary, you know, because I don't want -- I want him to be alert. I understand the food problem at the MDC. But I think that he also needs rest.

MR. STERN: I agree with you.

THE COURT: And, you know, put aside what this is about. Anyone who's a defendant has a right to be alert at his own trial. All right? That's my position on it. That's why I suggested that we put this over. I understand the witness has other responsibilities, but he wasn't compelled to be a witness, right? He chose to be a witness. He was asked and said he would do it. So he'll testify for a couple of hours tomorrow, and then he'll be on his way, unless anyone objects to that. Then we'll just follow that protocol.

Any objection?

MS. COHEN: No objection.

THE COURT: Okay. Let me put it on the record.

(Sidebar ends.)

(Continued on the next page.)

THE COURT: We're back on the record. After consulting with counsel, I've decided that we'll adjourn for the evening and resume tomorrow morning at 9:00. I ask that the witness return at 9:00 tomorrow morning. I appreciate everyone's cooperation. We'll see you-all tomorrow morning.

(Whereupon, the matter was adjourned to November 27, 2012 at 9:00 a.m.)

CERTIFICATE OF REPORTER.

I certify that the foregoing is a correct transcript of the record of proceedings in the above-entitled matter.

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Judi Johnson, RPR, CRR, CLR
Official Court Reporter

I N D E X

WITNESSES: **PAGE**

DEFENDANT'S EXHIBITS MARKED IN EVIDENCE